



# Oral & Maxillofacial Imaging Centers

## Indianapolis

9002 N. Meridian Street  
Ste# 208  
Indianapolis, IN 46260  
pho 317.663.8251  
fax 317.663.8256

## Chicago

30 North Michigan Avenue  
Ste# 1824  
Chicago, IL 46260  
pho 312.263.4000  
fax 312.263.4401

**Date** \_\_\_\_\_

**Patient** Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Alt. Phone \_\_\_\_\_  cell  Work  Other

**Referring Doctor** Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone \_\_\_\_\_ Alt. Phone \_\_\_\_\_  cell  other

**Legal Guardian** Name \_\_\_\_\_  Does Not Apply

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone \_\_\_\_\_ Alt. Phone \_\_\_\_\_  cell  other

Relationship To Patient \_\_\_\_\_

## Method Of Payment

Cash  Money Order  Credit Card

Check *(Please make check payable to: Oral & Maxillofacial Imaging Centers.  
For Indiana make check to: OMFIC-Indianapolis)*

I authorize the Oral & Maxillofacial Imaging Centers to make procedures deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility. I give consent to release any information including and regarding my exams at OMFIC to my referring physician or other health care providers involved in my treatment. I acknowledge that I have seen and understand OMFIC's Privacy Notice. I also agree to make full payment of any procedure at the time of the appointment.

Signature of Patient, legal guardian, or authorized agent of the patient:

\_\_\_\_\_ Date \_\_\_\_\_



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### ORAL & MAXILLOFACIAL IMAGING CENTERS - **PRIVACY NOTICE**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. PLEASE REVIEW IT CAREFULLY!

1. Purpose: The Oral and Maxillofacial Imaging Centers follows the privacy practices described in this Notice. For purposes of this Notice, the Oral and Maxillofacial Imaging Centers is defined as all professional staff, and employees (hereinafter OMFIC). OMFIC maintains your health information in records that will be maintained in a confidential manner, as required by law. However, OMFIC must use and disclose your health information to the extent necessary to provide you with quality health care. To do this, OMFIC must share your health information as necessary for treatment, payment and health care operations. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

2. How Will OMFIC Use My Health Information? Your health information may be used for the following purposes:

- Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment.
- Payment: We may use and disclose your health information to obtain payment for services we provide to you.
- Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your

healthcare or with payment for your healthcare, but only if you agree that we may do so.

- Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x rays or other similar forms of health information.
- Marketing Health Related Services: We may use or disclose your health information when we are required to do so by law.
- Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others.
- National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
- Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

3. Your Authorization Is Required for Other Disclosures. With the exception as described above in this Notice, we will not use or disclose your health information unless you authorize (permit) OMFIC in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

4. You Have Rights Regarding Your Health Information. You have the following rights regarding your health information, provided that you make a written request to invoke the right on the form provided by OMFIC:



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- Right to request restriction. You may request limitations on your health information we use or disclose for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular surgery), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. You may request a restriction on the form provided by OMFIC. The request should be filed by using the contact information at the end of this Notice.
- Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted. You may request confidential handling of information on the form provided by OMFIC. The request should be filed using the contact information at the end of this Notice.
- Right to inspect and copy. You have the right to inspect and copy your health information regarding decisions about your care including mental health notes, however, mental health records may be withheld if the health care provider determines, in their best judgment, that the information requested is detrimental to the physical and mental health of the patient, or likely to cause the patient to harm himself or another person. Upon written request and reasonable notice, you may request access and/or copies by using the contact information at the end of this Notice. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by OMFIC. OMFIC will comply with the outcome of the review.
- Right to request amendment. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by OMFIC, which requires certain specific information. The request should be filed using the contact information at the end of this Notice. OMFIC is not required to accept the amendment.
- Right to accounting of disclosures. You may request a list of the disclosures of your health information that have been made to persons or entities other than for health care treatment, payment, or operations in the past six (6) years, but not prior to April 14, 2003. After the first request in a 12 month period, there may be a charge. You may request an accounting of disclosures on the form provided by OMFIC. The request should be filed using the contact information at the end of this Notice.
- Right to a copy of this Notice. You may request a paper copy of this Notice at any time.

5. Requirements Regarding This Notice. OMFIC is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. OMFIC may change this Notice

and these changes will be effective for health information we have about you as well as any information we receive in the future. Each time you register at OMFIC for health care services as an inpatient or outpatient, you may receive a copy of the Notice in effect at that time.

6. Complaints. If you believe your privacy rights have been violated, you may file a complaint with OMFIC or with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or retaliated against in any way for making a complaint to OMFIC or the Department of Health and Human Services.

Please call Privacy Officer Dr. Francisco Eraso:

- If you have a complaint;
- If you have any questions about this Notice;
- If you wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or
- If you wish to obtain a form to exercise your individual rights described in paragraph 4.

Phone: (317) 663 8251, Fax: (317) 663 8256

Mail Address: Oral and Maxillofacial Imaging Center  
Indianapolis, 9002 North Meridian  
St Suite 208, Indianapolis, IN 46260

#### OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.