CASE WESTERN RESERVE UNIVERSITY

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice will tell you about the ways in which CASE WESTERN RESERVE UNIVERSITY ("CWRU") protects, uses and discloses your protected health information ("PHI"). This Notice also describes your rights and certain obligations we have regarding the use and disclosure of PHI. If you have any questions about this Notice of Privacy Practices ("Notice"), please contact CWRU's Privacy Officer, at CASE WESTERN RESERVE UNIVERSITY, 10900 Euclid Avenue, Cleveland, Ohio 44106.

PHI means any information, transmitted or maintained in any form or medium, which CWRU creates or receives that relates to your physical or mental health, the delivery of health care services to you or payment for health care services and that identifies you or could be used to identify you. We maintain your PHI in a record we create of the services and items you receive from CWRU. This Notice applies to all of those records created, received or maintained by CWRU.

We are required by law to: make sure that PHI is kept private; give you this Notice of our legal duties and privacy practices with respect to your PHI; and comply with the currently effective terms of this Notice.

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU

The following paragraphs describe different ways that we use and disclose PHI.

Use for Treatment, Payment, or Health Care Operations

We are permitted to use and disclose your PHI (1) to provide treatment to you, (2) to be paid or request payment for our services, and (3) to conduct health care operations. This section of this Notice discusses each of these types of uses and disclosures of PHI.

- **For Treatment.** We may use PHI about you to provide you with health care treatment or services. For example, we may use your PHI when performing dental procedures. We may disclose PHI about you to CWRU personnel, as well as to doctors, nurses, hospitals, clinics, or other health care providers who are involved in your care. For example, a doctor treating you for a medical condition may need to know the medications which have been prescribed for you, or the services and items that have been provided to you. CWRU may also share PHI about you in order to coordinate health care services and items that you may need.

- **For Payment.** We may use and disclose PHI about you so that the services and items that you receive from CWRU may be billed to and payment may be collected from you, an insurance company, or a third party payor. For example, we may need to give your health plan information about the services or items that you received so that your health plan will pay us or reimburse you for the services or items.

- **For Health Care Operations.** We may use and disclose PHI about you for health care operations. These uses and disclosures are necessary to make sure you receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in providing services to you. We may also disclose information to doctors, nurses, hospitals, clinics, and other health care providers, for review and learning purposes. We may remove information that identifies you from this set of PHI so others may use it to study health care and health care delivery without learning the names of the specific individuals.

Other Uses and Disclosures of PHI

Listed below are a number of other ways that CWRU is permitted or required to use or disclose PHI. This list is not exhaustive. Therefore, not every use or disclosure in a category is listed.

- **Appointment Reminders.** We may use and disclose protected health information to contact you as a reminder that you have an appointment with us.

- **Individuals Involved in Your Care or Payment for Your Care.** We may release PHI about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose PHI about you to a person or entity assisting in an emergency so that your family can be notified about your condition, status and location.

- **As Required By Law.** We will disclose PHI about you when required to do so by federal, state, or local law.

- **Public Health Risks.** We may disclose PHI about you for public health activities, including to prevent or control disease or, when required by law, to notify public authorities concerning cases of abuse or neglect.

- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official as permitted by law.

- **Coroners and Medical Examiners.** We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Research.** Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, we might disclose PHI to be used in a research project involving the effectiveness of certain dental procedures. In some cases, we might disclose PHI for research purposes without your knowledge or approval. However, such disclosures will be made only if approved through a special process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with an individual's need for privacy of their PHI.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Military and Veterans.** If you are a member of the armed forces, we may release PHI about you as required by military command authorities.

- **Health-Related Benefits and Services.** We may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

- **Workers' Compensation.** We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Fundraising.** We may disclose PHI about you for fundraising purposes. Any such disclosure of PHI will be limited in scope and disclosed only to our business associates or to a charitable organization which is obligated to act for the benefit of CWRU. If you do not want CWRU to contact you about fundraising, you must notify the CWRU Privacy Officer in writing. Further information about disclosures for fundraising purposes may be found in CWRU's Policies and Procedures, "Fundraising."

Other uses and disclosures will be made only upon your written authorization. You also have the right to revoke such authorization, in writing, except where we have previously taken action in reliance on your prior authorization or if the authorization was a condition to obtaining insurance or health plan coverage and applicable law provides the insurer or health plan with the right to contest a claim under the policy.

Certain provisions of Ohio law may now, or in the future, impose greater restrictions on uses and/or disclosures of PHI or otherwise be more stringent than federal rules protecting the privacy of PHI. If such provisions of Ohio law apply to a use or disclosure of PHI or under other circumstances described in this Notice, CWRU must comply with those provisions.

When required to do, the Plan will disclose only the minimum amount of PHI necessary to accomplish the intended purpose of a use disclosure or request for PHI.

NOTE: A large print version of this Notice is available upon request.

YOUR RIGHTS REGARDING PHI

You have the following rights with respect to your PHI:

- **Right to Inspect and Copy.** You have the right to inspect and copy your PHI maintained by CWRU. Generally, this information includes health care and billing records. You do not have a right of access to (1) psychotherapy notes; (2) information prepared in anticipation of or for use in, a civil, criminal, or administrative action; and (3) PHI maintained by CWRU that is (a) subject to the Clinical Laboratory Improvements Amendments ("CLIA") of 1988, 42 U.S.C. 263a, if access to the individual would be prohibited by law, or (b) exempt from CLIA pursuant to 42 CFR 493.3(a)(2). Under certain circumstances, you also do not have a right of access to information created or obtained in the course of research involving treatment or received from someone other than a health care provider under a promise of confidentiality.

  To inspect and copy PHI maintained by CWRU, you must submit your request in writing to CWRU's Privacy Officer. We may charge a fee for the costs of copying, mailing or other supplies associated with you request. We may deny your request to inspect and copy your PHI for the reasons set forth above or under certain other limited circumstances. If you are denied access to PHI other than for a reason stated above, you will receive a written denial. You may request that the denial be reviewed. Thereafter, a licensed health care provider chosen by CWRU will review your request and the denial. The person conducting the review will not be the person who originally denied your request. We will comply with the outcome of the review.

- **Right to Request Amendment.** You may ask us to amend the PHI we have about you. You have the right to request an amendment for so long as the information is kept by or for CWRU. To request an amendment to your PHI, your request must be made in writing and submitted to CWRU's Privacy Officer. In addition, you must provide a reason that supports your request. We will generally make a decision regarding your request for amendment no later than 60 days after receipt of your request. However, if we are unable to act on the request within this time, we may extend the time for 30 more days but we will provide you with a written notice of the reason for the delay and the approximate time for completion. If we deny your requested amendment, we will provide you with a written denial.

  We have the right to deny your request for an amendment if it is not in writing or does not include a reason to support the request. We are not required to agree to your request if you ask us to amend PHI that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the PHI kept by or for CWRU; is not part of the PHI which you would be permitted to inspect and copy; or is already accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures of PHI we have made about you. We do not have to list certain disclosures such as those made for the purposes of treatment, payment, or healthcare operations, pursuant to a prior authorization by you or for certain law enforcement purposes.

  To request this list or accounting of such disclosures, your request must be submitted in writing to CWRU's Privacy Officer. Your request must also state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should also specify the format of the list you prefer (i.e. on paper or electronically). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restriction of Uses and Disclosures.** You have the right to request that we restrict the uses and disclosures of PHI about you to carry out treatment, payment or health care operations and/or to individuals involved in your care. We cannot restrict disclosures required by law or requested by the federal government to determine if we are meeting our privacy protection obligations. *We are not required to agree to your request;* however, if we do agree, we will comply with your request unless the information is needed to provide you emergency health care treatment. To request restrictions, you must make your request in writing to CWRU's Privacy Officer. Your request must specify (1) what PHI you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (i.e., disclosures to your spouse). We may terminate our agreement to the restriction if you orally agree to the termination and it is documented, you request the termination in writing, or we inform you that we are terminating our agreement with respect to any information created or received after receipt of our notice.

- **Right to Request Confidential Communications.** You also have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to CWRU's Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to Receive Notice Electronically.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To obtain a paper copy of this notice, please write to or call CWRU's Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices that are described in this Notice. We reserve the right to make the revised or changed privacy practices applicable to PHI we already have about you as well as any information we receive in the future. A copy of our current notice will be posted at CWRU. Prior to a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in this Notice, we will promptly revise the Notice. The Notice will contain the effective date on the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with CWRU or with the Secretary of the Department of Health and Human Services. To file a complaint with CWRU, write to **Privacy Officer, CWRU, 10900 Euclid Avenue, Cleveland, OH 44106-7048**. All complaints must be in writing. ***You will not be penalized or retaliated against for filing a complaint.***

OTHER USES OF PHI

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

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of CWRU's Notice of Privacy Practices.

Date: _____

_____
Signature of Patient, Guardian or Legal Representative

_____
Printed Name of Patient, Guardian or Legal Representative

_____
Relationship of Guardian or Legal Representative to Patient

The individual or the individual's legal representative did not provide a written acknowledgment of receipt of this Notice of Privacy Practices. The following explains the good faith efforts to obtain the written acknowledgment and the reasons why the acknowledgment was not obtained: _____

_____

_____

_____

_____

Patients' Name_____

Last First Initial Date of Birth

1. Purpose of initial visit_____
2. Are you aware of any dental problems you have?_____
3. When was your last dental visit?_____
4. What was done at that time?_____
5. When was your last cleaning?_____
6. When were x-rays last taken?_____
7. Previous dentist's name?_____

Address:_____Telephone:_____

Yes No Have you made regular visits?
Yes No Have you lost any teeth or have any teeth been removed?
Yes No Have they been replaced?
If yes, how have they been replaced?

A. Fixed Bridge Age_____
B. Removable Bridge Age_____
C. Denture Age_____
D. Implants Age_____

Yes No Are you happy with the replacement?
If not, explain_____
Yes No Would you like to know about permanent replacements?
Yes No Have you ever had any problems or complications with previous dental treatment?
If yes, explain_____
Yes No Do you clench or grind your teeth?
Yes No Does your jaw click or pop?
Yes No Have you experienced any pain or soreness in the muscles on your face or around your ear?
Yes No Do you have frequent headaches, neck aches or shoulder aches?
Yes No Does food get caught in your teeth?
Yes No Are your teeth sensitive to (circle all that apply): Heat Cold Sweets Pressure
Yes No Does your gums bleed or hurt?
How often to your brush your teeth?_____When_____
Yes No Do you use dental floss? How often?_____
Yes No Are any of your teeth loose, tipped, shifted, or chipped?
Yes No Are you unhappy with the appearance of your teeth?
Yes No Do you feel your breath is offensive at times?
Yes No Have you ever had gum treatment or surgery?
What kind?_____Where_____Date_____
Yes No Have you had any orthodontic work?
Yes No Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?_____
How do you feel about your teeth in general?_____
Yes No Do you have any questions or concerns?

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE

PATIENT/GUARDIAN'S SIGNATURE_____DATE_____

DENTIST'S SIGNATURE_____DATE_____

DENTAL HISTORY

Patients' Name_____

Last First Initial Date of Birth

Physician's

Name_____

Address_____

When was your last complete physical?_____

CIRCLE THE APPROPRIATE ANSWER

Yes No Are you taking any medications or substances? If yes, please list below.

_____

Yes No Do you have any allergies (including medications)? If yes, please list below.

_____

Yes No Are you pregnant or suspect you may be?
Yes No Do you use any birth control medications?
Yes No Have you ever been treated for, or told you may have heart disease?
Yes No Do you have a pacemaker or an artificial heart valve implant?
Yes No Have you ever had Rheumatic Fever?
Yes No Are you aware of any heart murmurs?
Yes No Do you have high or low blood pressure?
Yes No Have you had a serious illness or major surgery?
If yes, explain_____
Yes No Have you had radiation treatment, or chemotherapy?
Yes No Do you have Arthritis or Rheumatism?
Yes No Do you have any artificial joints/prosthesis?
Yes No Do you have any blood disorders, such as anemia, leukemia, etc.
Yes No Have you ever bled excessively after being cut or injured?
Yes No Do you have any stomach problems?
Yes No Do you have any kidney problems?
Yes No Do you have any liver problems?
Yes No Are you diabetic?
Yes No Do you have asthma?
Yes No Do you have epilepsy or seizure disorders?
Yes No Do you have, or have you had venereal disease?
Yes No Have you tested positive for HIV?
Yes No Have you tested positive for AIDS?
Yes No Have you ever, or do you test positive for hepatitis?
Yes No Do you or have you ever had TB?
Yes No Do you smoke, chew, use snuff or any forms of tobacco?
Yes No Do you consume alcoholic beverages?
Yes No Do you habitually use controlled substances?
Yes No Have you had psychiatric treatment?
Yes No Do you have any disease, condition, or problem not listed?
If so, explain_____
Yes No Is there anything else we should know about your health that we have not covered on this form?

_____

Yes No Would you like to speak to the doctor privately about any problem?

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE

PATIENT/GUARDIAN'S SIGNATURE_____ DATE_____

DENTIST'S SIGNATURE_____ DATE_____

MEDICAL HISTORY

PATIENT CONSENT AND RELEASE

Case Western Reserve University School of Dental Medicine

In consideration of the reduced rates given me by Case Western Reserve University, I hereby release and agree to hold harmless Case Western Reserve University, its doctors, dentists, employees, agents, and students from any and all liability arising out of or in connection with any injuries or damages which I may suffer or sustain due to negligence or malpractice while receiving treatment in the Dental Clinic or while on the premises.

☐ I AM REQUESTING COMPREHENSIVE CARE. THIS INCLUDES, BUT IS NOT LIMITED TO COMPREHENSIVE EXAM, TREATMENT PLANNING AND NECESSARY X-RAYS, CLEANINGS, GUM TREATMENTS, ROOT CANAL, AND RESTORATIVE CARE AS NEEDED.

☐ I AM REQUESTING TREATMENT FOR A SPECIFIC PROBLEM AND/OR I HAVE BEEN REFERRED BY MY REGULAR DENTIST FOR SPECIFIC TREATMENT, INCLUDING BUT NOT LIMITED TO ORAL SURGERY, PERIODONTAL THERAPY OR ENDODONTIC THERAPY. I DO NOT EXPECT A COMPREHENSIVE EXAMINATION, NOR WILL I HOLD CASE WESTERN RESERVE UNIVERSITY, ITS DOCTORS, DENTISTS, EMPLOYEES, AGENTS AND STUDENTS LIABLE FOR DIAGNOSIS AND/OR TREATMENT OF ANY DISORDER NOT RELATED TO THE SPECIFIC PROBLEM FOR WHICH I OR MY DENTIST REQUESTED TREATMENT.

Name of Referring Dentist: _____

Describe Specific Problem or Reason for Referral: _____

_____

_____

I am aware that the Dental Clinics of Case Western Reserve University are part of an educational institution in which students receive training and that dental services are offered at reduced rates.

I understand that all services are performed by students-in-training under faculty supervision and I further understand that, at the option of a faculty member, faculty and other employees, may also provide services when, in the opinion of a faculty member, such a substitution is appropriate.

I consent to have students, and/or faculty, and/or staff of Case Western Reserve University request and to have released to them any information regarding my prior health, medical or hospital treatment when, in the opinion of a faculty member, such information is essential to the examination and/or diagnosis and/or treatment process.

I consent to all such examination procedures, tests and x-rays and dental treatment ordered and/or performed by the students and/or teaching staff and as indicated by sound and prudent dental practices.

If the use of pre-medication and/or local anesthesia is indicated, I consent to the administration of such pre-medication and/or local anesthesia as the teaching staff may deem advisable and proper.

I understand that changes in the accepted treatment plan may be necessary during the course of treatment and that I will be informed of these changes verbally and/or in writing.

I consent to the taking and use of photographs, radiographs (x-rays), tape recordings, video recordings, or drawings as deemed necessary or desirable by members of the faculty or staff for the purpose of education, including publication in professional journals and books or for presentation before professional audiences. I hereby waive any property rights I have to such photographs, radiographs (x-rays), tape recordings, video recordings, or drawings. I further waive any rights of privacy that I may have to this information under any applicable federal, state, or local law.

I am also aware that, based upon personal health status and/or the educational needs and/or resources of the School of Dental Medicine, dental treatment may not be provided to me at all or that limited treatment only may be provided.

I authorize the School of Dental Medicine and its agents and employees to release information about the treatment received at its clinics to government agencies, dental insurers and to others as may be required by law.

I fully understand and consent to the conditions stated above.

Witnessed by:

_____ _____

Witness Patient Date

_____ _____

Witness Parent or Guardian

Center 2 hole punch

(WHITE PAPER – BLACK INK)

CWRU SCHOOL OF DENTAL MEDICINE
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PLEASE COMPLETE BOTH SIDES

HAVE YOU BEEN A PATIENT AT THE DENTAL SCHOOL BEFORE? ☐ YES ☐ NO IF YES, WHEN? _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

_____
LAST NAME FIRST M.I.

PATIENT SEX: ☐ MALE ☐ FEMALE BIRTH DATE: _____

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

HOME PHONE: (____) _____-_____ WORK PHONE: (____) _____-_____ CELL: (____) _____-_____

PAGER/ EXT: _____ E-MAIL ADDRESS: _____

PREVIOUS NAME: _____ PREFERRED NAME: _____

PHYSICIAN'S NAME: _____ PHONE NUMBER: (____) _____-_____

SOCIAL SECURITY #: _____-_____-_____

_____ (____) _____-_____
NEAREST RELATIVE NOT LIVING WITH YOU PHONE NUMBER

(OPTIONAL) IF YOU WISH TO IDENTIFY YOURSELF WITH A PARTICULAR ETHNIC GROUP, PLEASE CHECK THE FOLLOWING:

AFRICAN-AMERICAN, BLACK ___, AMERICAN INDIAN, ALASKAN NATIVE ___, ASIAN-AMERICAN ___, ASIAN/ INDIAN ___, HISPANIC, LATINO ___, MEXICAN-AMERICAN, CHICANO ___, PUERTO RICAN ___, NATIVE HAWAIIAN, PACIFIC ISLANDER ___, MULTIRACIAL ___, WHITE, CAUCASIAN ___, OTHER ___.

RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

BIRTH DATE: _____ SOCIAL SECURITY #: _____-_____-_____

INSURANCE NAME: _____ GROUP #: _____

POLICY HOLDER'S NAME: _____ POLICY #: _____

BIRTH DATE: _____ SOCIAL SECURITY #: _____-_____-_____

EMPLOYER: _____ PHONE NUMBER: (_____) _____-_____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENTS IN FULL OF ALL ACCOUNTS. I UNDERSTAND THAT CWRU SCHOOL OF DENTAL MEDICINE IS A NON PROVIDER FOR MOST DENTAL INSURANCE CARRIERS, AND THAT ALL TREATMENT MUST BE PAID FOR IN ADVANCE. I AGREE TO PAY THE MOST CURRENT SCHOOL FEE REGARDLESS OF THE FEE LISTED IN MY TREATMENT PLAN, IF MY TREATMENT PLAN ESTIMATE IS MORE THAN 24 MONTHS OLD.

_____
SIGNATURE – PATIENT OR GUARDIAN

OFFICE USE

_____ _____ _____
ASSIGNED STUDENT SOEL CODES CLINIC

Patient File Number
