FIRST CHOICE DENTAL GROUP, S.C.

NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect **01/16/2026** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change the Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

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 operation 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 our 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 of 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. In cases where a patient requires home supervision following dental care (i.e. Sedation Dentistry) we reserve the right to discuss necessary health information with the caretaker. Please note our staff is "cross-trained" and will have equal access to patient health information.

Marketing Health-Related Services: We will not use our health information for marketing communications without your written authorization. Photos taken prior and after treatment will not be used for marketing purposes without your consent.

Required By Law: 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 or 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).
E-Mail: We may contact you via e-mail regarding appointments, special promotions and education provided you have given us your e-mail address. We will not sell or distribute this information to any outside entities. You may request to stop this communication at any time.

SPECIAL PRIVACY PROTECTIONS

Substance Use Disorder (SUD) Records: Health information related to substance use disorder treatment, when applicable, may be protected by federal law (42 CFR Part 2). We will not use or disclose this information except as permitted or required by law, or with your written authorization, unless an exception applies (such as a medical emergency or as required by law).
You have the right to receive a copy of any authorization you sign allowing the disclosure of substance use disorder records.
Reproductive Health Information: We are prohibited from using or disclosing your reproductive health information for purposes of investigating or imposing liability on any person for seeking, obtaining, providing, or facilitating lawful reproductive healthcare. We will not disclose reproductive health information for these purposes unless required by law and permitted under applicable federal privacy rules.

PATIENT RIGHTS

Access: You have the right to inspect or obtain a copy of your health information, with limited exceptions. You may request that we provide copies in a format other than paper. We will use the format you request unless it is not practicable to do so. Requests for access to your health information must be made in writing. You may obtain a request form by contacting us using the information listed at the end of this Notice. Charges may apply for providing copies of your health information.
Disclosure Accounting: You have the right to receive an accounting of certain disclosures of your health information made by us or our business associates for purposes other than treatment, payment, or healthcare operations, for the six years prior to the date of your request, but not for disclosures made before April 14, 2003.
Restriction: You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations. We are not required to agree to your request, but if we do, we will comply with the agreed restriction except in emergency situations.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. Your request must be made in writing and must specify the alternative means or location for communication.
Amendment: You have the right to request that we amend your health information if you believe it is incorrect or incomplete. Your request must be made in writing and must explain why the amendment is requested. We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice electronically, you have the right to request a paper copy of this Notice at any time.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you be alternative means or at alternative locations, you ay complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Danielle Turner
Telephone: 608-308-2934
Fax: 608-308-2949
E- Mail: info@firstchoicedental.com
Address: 440 Science Dr.
Ste. 100
Madison, WI 53711

First Choice Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

I have received a copy of and have read First Choice Dental's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my protected health information may be used or disclosed by First Choice Dental and of my rights with respect to my protected health information.

I am giving my consent to use and disclose of my protected health information to carry out treatment, payment activities, and health care operations *(without signature, we may decline to treat you)*.

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up items that contain PHI. I am giving consent to disclose of my patient care records and protected health information to the following person(s), including those involved in my care or payment for that care:

_____ _____

_____ _____

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the office. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation.

_____ _____
Patient Name Patient Signature

_____ _____ _____
Signature of Patient's Representative if Patient is unable to sign Relationship Date

To be completed by First Choice Dental personnel if form is not signed:

1. Was the patient provided with a copy of the Notice of Privacy Practices?

- ☐ Yes
- ☐ No

2. Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of the Notice, and explain why the patient was unable or unwilling to sign this form:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify):_____

_____