

NOTICE OF PRIVACY PRACTICES

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

Effective Date: January 15th 2026

1. OUR DUTIES REGARDING YOUR HEALTH INFORMATION

Black Creek Dental ("we," "our," or "us") is required by law to:

- Maintain the privacy and security of your protected health information (PHI);
- Provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices;
- Follow the terms of this Notice currently in effect; and
- Notify you promptly if a breach occurs that may have compromised the privacy or security of your information.

Protected health information includes information that identifies you and relates to your past, present, or future physical or mental health condition, the provision of healthcare to you, or payment for that care.

2. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

A. Treatment

We may use and disclose your health information to provide, coordinate, or manage your dental care. Examples include:

- Sharing information with dental specialists, laboratories, hygienists, or other providers involved in your care;
- Referring you to another provider or coordinating care with physicians or pharmacies.

B. Payment

We may use and disclose your health information to obtain payment for services provided to you. Examples include:

- Submitting claims to dental or medical insurance plans;
- Determining eligibility, benefits, or coverage;
- Billing and collection activities.

C. Health Care Operations

We may use and disclose your information for our business operations, such as:

- Quality assessment and improvement activities;
 - Staff training and credentialing;
 - Practice management, audits, and compliance activities.
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3. USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION

We may use or disclose your information without your authorization in the following circumstances, as permitted or required by law:

- **Public health activities** (e.g., disease prevention or reporting);
 - **Health oversight activities** (e.g., audits, investigations, inspections);
 - **Legal proceedings** (e.g., court orders, subpoenas);
 - **Law enforcement purposes** as required by law;
 - **To avert a serious threat to health or safety;**
 - **Workers' compensation** claims;
 - **Coroners, medical examiners, and funeral directors;**
 - **As required by federal, state, or local law.**
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4. SUBSTANCE USE DISORDER (SUD) INFORMATION – SPECIAL PROTECTIONS

Some health information related to substance use disorder (SUD) diagnosis, treatment, or referral may be protected by **federal law (42 C.F.R. Part 2)**.

- SUD information may be used and disclosed for **treatment, payment, and healthcare operations** if you have provided a valid consent, consistent with federal law.
- SUD information **cannot be used or disclosed** for certain purposes, such as civil, criminal, administrative, or legislative proceedings against you, without a specific legal authorization or court order.
- We are prohibited from re-disclosing SUD information unless permitted by law.

You have the right to revoke consent for SUD information disclosures in writing, except to the extent we have already relied on it.

5. Reproductive and Sexual Health Information

In limited circumstances, we may collect or maintain information related to reproductive or sexual health (“Reproductive Health Information”) as part of your dental record. This information is collected only when relevant to your dental care, treatment planning, medication safety, anesthesia considerations, or other healthcare operations, or when you voluntarily provide it to us.

Reproductive Health Information may include, for example, information related to pregnancy status, fertility treatment, or medications that may affect dental treatment. We do not collect such information for non-clinical purposes.

Reproductive Health Information is treated as protected health information (“PHI”) and is used and disclosed only as permitted by the Health Insurance Portability and Accountability Act (HIPAA), applicable Wisconsin law, and this Privacy Notice. We do not sell Reproductive Health Information or use it for marketing or targeted advertising.

We may disclose Reproductive Health Information only as necessary for treatment, payment, and healthcare operations; to service providers and business associates acting on our behalf under confidentiality obligations; as required by law or lawful legal process; or with your written authorization.

We maintain appropriate administrative, technical, and physical safeguards to protect Reproductive Health Information from unauthorized access, use, or disclosure. We retain such information in accordance with Wisconsin record-retention requirements and applicable federal law.

6. USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will obtain your written authorization before using or disclosing your health information for:

- Marketing purposes;
- Sale of your health information;
- Most uses or disclosures of psychotherapy notes (if applicable);
- Any other use not described in this Notice.

You may revoke an authorization at any time in writing, except where we have already relied on it.

7. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

A. Inspect and Obtain a Copy

You may request access to your dental and health records, in paper or electronic form.

B. Request an Amendment

You may request correction of information you believe is incorrect or incomplete.

C. Request an Accounting of Disclosures

You may request a list of certain disclosures we have made of your health information.

D. Request Restrictions

You may request limits on how we use or disclose your information. We are not required to agree to all requests, except where required by law.

E. Request Confidential Communications

You may request that we communicate with you in a specific way or at a specific location.

F. Receive a Paper Copy

You may request a paper copy of this Notice at any time, even if you agreed to receive it electronically.

8. FUNDRAISING COMMUNICATIONS

If we contact you for fundraising purposes, you have the right to opt out of receiving such communications. We will not condition treatment or payment on your choice.

9. BREACH NOTIFICATION

We will notify you if a breach of your unsecured protected health information occurs, as required by law.

10. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with:

Thomas Lornson
Black Creek Dental
207 S. Main Street, Black Creek WI 54106
920-984-3315
info@blackcreekdental.com

You may also file a complaint with the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

11. CHANGES TO THIS NOTICE

We reserve the right to change this Notice and make the revised Notice effective for all health information we maintain. The current Notice will be available in our office and on our website, if applicable.

12. CONTACT INFORMATION

If you have questions about this Notice or your privacy rights, please contact:

Privacy Officer: Thomas Lornson

Practice Name: Black Creek Dental
Address: 207 S. Main Street, Black Creek WI 54106

Phone: 920-984-3315
Email: info@blackcreekdental.com

PATIENT CONSENT AND ACKNOWLEDGMENT

NOTICE OF PRIVACY PRACTICES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (OPTIONAL)

I voluntarily consent to Black Creek Dental using and disclosing my protected health information (PHI) for the purposes of treatment, payment, and healthcare operations, as described in the Notice of Privacy Practices.

I understand that:

- This consent is not required to receive treatment.
- I may revoke this consent at any time in writing, except to the extent that the practice has already relied on it.
- Revocation will not affect actions already taken based on my consent.
- My protected health information may be shared with other healthcare providers, dental laboratories, insurance plans, and business associates involved in my care or payment.

Patient Signature (Consent): _____

Date: _____

ACKNOWLEDGMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the **Notice of Privacy Practices of Black Creek Dental**. This Notice describes how my protected health information may be used and disclosed, and how I can access this information.

I understand that:

- The dental practice may use and disclose my protected health information for treatment, payment, and healthcare operations, as described in the Notice.
- I have certain rights regarding my protected health information, as outlined in the Notice.
- The Notice applies to all protected health information maintained by the practice, including dental and medical information.
- The Notice may be revised from time to time, and updated versions will be made available.

I understand that acknowledging receipt of this Notice **does not constitute consent** for the use or disclosure of my protected health information, but only confirms that I have received and reviewed the Notice.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

If signed by a personal representative:

Name of Personal Representative: _____

Relationship to Patient: _____

For Office Use Only

If the patient is unable or unwilling to sign this acknowledgment, staff must document the reason below in accordance with HIPAA requirements.

Reason acknowledgment was not obtained:

- Patient refused to sign
- Patient unable to sign
- Other: _____

Staff Member Name: _____

Staff Signature: _____

Date: _____