

We Want to REWARD you!

Each time you refer a new patient or family to our office you will receive one of the following \$25.00 gift cards.

(Please indicate your preference.)

- Broadmoor Dental (\$25 Credit for your next visit)
- Bed, Bath, & Beyond
- Borders Books
- The Home Depot
- Starbucks
- Safeway

Please remind your friends and family to mention your name so we may thank you for your referrals!

*New referrals are not inclusive of your immediate family.

Who can we reward for referring YOU?

How would you like a Digital Smile Makeover?

The *LumiSmile* digital smile makeover gives you the chance to see what it could mean if you whitened and brightened your smile, closed some gaps, changed tooth shape, and/or fixed broken or discolored teeth. It's **free** and all it takes is a quick photograph to make it happen!

The photograph is e-mailed to Denmat for smile design. The information they need is your photograph, name, and phone number. Since this information is being released, under HIPPA privacy laws, we need your approval to release the data. So here is the consent:

I understand I have the right to receive a copy of this authorization, I have the right to refuse to sign this authorization and I have the right to withdraw this authorization at any time. I acknowledge that the photograph to be released and related information may include material that is protected by federal law and I acknowledge the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient. By providing my phone number and authorization submission of a *LumiSmile*, I authorize my dental office and/or Den-Mat Holdings, LLC, to contact me at the phone number submitted within the *LumiSmile* portal with respect to *LumiSmile* or LUMINEERS, even if I am registered with the federal or state Do Not Call registries.

- Yes, I want a free *LumiSmile*!

Print _____

Sign _____

Date _____

- No, I do not want a *LumiSmile*. Please retain my photograph for your records.

Your Smile Survey.

- 1) Do you like the appearance of your smile?
Y N
- 2) Do you like the appearance of your teeth?
Y N
- 3) Do you like the color of your teeth?
Y N
- 4) Do you have spaces between your teeth that you don't like?
Y N
- 5) Do you like the size and shape of your teeth?
Y N
- 6) Are there old fillings or dental work that you don't like looking at?
Y N
- 7) What would you like to change the most about the appearance of your teeth?

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____
Have received a copy of this office's Notice of Privacy Practices.

Sign _____

Date _____

Broadmoor Dental

Nicolas R. Pruett, D.D.S.

Christopher D. Mazzola, D.D.S ~ Christina M. Mazzola, D.D.S

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Broadmoor Dental Notice of Privacy Practices (HIPAA)

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/state law to maintain the privacy of your health information. We are also required to give you the notice about our privacy practices, our legal duties, and your right concerning your health information. We must follow the privacy practices that are described in the notice taking effect 06/08/11 and remaining 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 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 this notice and make the new notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION-We use and disclose health information about you for treatment, payment, healthcare operations. For example, we may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use and disclose your health information to obtain payment for services we provided to you. We may use and disclose your health information in programs, accreditations, certifications, licensing and/or credential activities.

YOUR AUTHORIZATION-In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose, with the ability to revoke this authorization in writing at any time. Unless you gave us a written authorization, we cannot use or disclose your health information for any reason except those described in 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 health care, but only if you agree that we may do so.

PERSON 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 will not use your information for marketing communications without your written authorization.

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 and safety of others.

NATIONAL SECURITY-We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances to authorized federal officials health information required by lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials having lawful custody of protected health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

APPOINTMENT REMINDERS-We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

ACCESS- You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies and you must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice.

DISCLOSURE ACCOUNTING- You have the right to receive a list of instances which we disclosed health information for purposes, other than treatment, payment healthcare operations and certain other activities, for the last 6 years from the current date of the request. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional request.

RESTRICTION- You have the right to request that we communicate with you about your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

ALTERNATIVE COMMUNICATION-You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT-You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended.

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 right, 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 by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this notice. You may also submit a warrant to the U.S. Department of Health and Human Services.

Contact Officer: Dr. Nicolas R. Pruett
Fax: 719.576.5566

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