OMNIBUS Rule
HIPAA NOTICE OF PRIVACY PRACTICES
for the Facility of:

Legal Entity Practice Name: BENDER DENTAL GROUP

Mailing Address: 313 PRIMROSE LN, STE A/B, MOUNTVILLE, PA 17554

Effective date: February 16, 2026

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

For purposes of this Notice, "we," "our," and "us" refer to the health care facility named above. "You" and "your" refer to our patients or their authorized legal representatives.

We are committed to protecting the privacy of your Protected Health Information (PHI). We follow the Health Insurance Portability and Accountability Act (HIPAA), its implementing regulations, and all amendments, including the 2026 revisions concerning Substance Use Disorder (SUD) treatment information governed by 42 CFR Part 2.

OUR RESPONSIBILITIES

We are required to:

- Maintain the privacy of your PHI, including SUD information that may carry extra confidentiality protections under 42 CFR Part 2
- Provide you with this Notice of our legal duties and privacy practices
- Notify you following a breach of unsecured PHI
- Follow the terms of this Notice

HOW WE MAY USE AND DISCLOSE YOUR PHI WITHOUT YOUR WRITTEN AUTHORIZATION:

- **Treatment:** We may use and share your PHI with other dentists, physicians, or health care professionals who are treating you. Example: We send x-rays to a specialist for a consultation
- **Payment:** We may use and share your PHI to bill and get payment from health plans or other entities. Example: We submit information to your dental plan to obtain payment
- **Health care operations:** We may use and share your PHI to run our practice, improve your care, and contact you when necessary. Example: Quality assessment, auditing, or customer service
- **Public health and safety:** We may share PHI for public health reporting, to report abuse or neglect, to avert a serious threat to health or safety, or for product recalls, as permitted by law
- **Health oversight and law enforcement:** We may share PHI with health oversight agencies, for law enforcement purposes, or as required by a court or administrative order, subpoena, or similar process, as permitted by law
- **Research:** We may use or share PHI for research under specific conditions approved by an Institutional Review Board or privacy board, or with your authorization
- **Workers' compensation and other government functions:** We may share PHI for workers' compensation claims and for specialized government functions as permitted by law
- **Business associates:** We may share PHI with third parties who provide services for us (business associates) under contracts requiring them to protect your information

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

- Most uses and disclosures of psychotherapy notes (if any)
- Marketing communications, sales of PHI, and other uses not described in this Notice
- Sharing your PHI for purposes not permitted by law without your written permission

YOUR RIGHTS REGARDING YOUR PHI:

- **Right to access:** You can ask to see or get an electronic or paper copy of your dental record and other PHI we have about you. We will provide a copy or a summary of your health information within required time frames and may charge a reasonable, cost-based fee
- **Right to request an amendment:** You can ask us to correct information you think is incorrect or incomplete. We may say "no," but we will tell you why in writing within 60 days
- **Right to request restrictions:** You can ask us not to use or share certain PHI for treatment, payment, or health care operations. We are not required to agree, except when you pay out-of-pocket in full and request that we not share information with your health plan for that service
- **Right to request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address
- **Right to an accounting of disclosures:** You can ask for a list of certain disclosures we have made of your PHI for the six years prior to your request
- **Right to a paper copy of this Notice:** You can ask for a paper copy of this Notice at any time
- **Right to choose a personal representative:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information, consistent with applicable law

OUR DUTIES:

- We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI
- We must follow the duties and privacy practices described in this Notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time

SPECIAL NOTICE ABOUT SUBSTANCE USE DISORDER (SUD) RECORDS (42 CFR PART 2):

If we create, maintain, or receive SUD records protected by 42 CFR Part 2, those records are subject to additional protection. Part 2 prohibits us from using or disclosing SUD records for many purposes without your written consent, including certain treatment, payment, and health care operations. Part 2 records generally may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you without your written consent or a specific court order. You may revoke your consent as permitted by Part 2. We may combine this notice with Part 2 Patient Notice so long as all required elements are included.

FUNDRAISING COMMUNICATIONS:

If we contact you for fundraising, you will have a clear opportunity to opt out of receiving further communications. We will not use or share 42 CFR Part 2 SUD records for fundraising without your written consent.

QUESTIONS AND COMPLAINTS:

If you have questions or want to exercise your rights, contact:
You may file a complaint with:

U.S. Department of Health & Human Services — Office for Civil Rights
200 Independence Ave., SW
Washington, DC 20201
Phone: 877-696-6775

or

Our Privacy Officer:

Name: DR. AMAR PATEL

Facility: BENDER DENTAL GROUP

Address: 313 PRIMROSE LN. STE A/B, MOUNTVILLE, PA 17554

Phone: 717.285.3030 Fax: 717.285.2906

Email: OFFICE@BENDERDENTALGROUP.COM

We will not retaliate against you for filing a complaint.

ACKNOWLEDGMENT:

You will be asked to sign an acknowledgment that you received this Notice.

NOTE: This NPP is written in plain language. We will post the current Notice in our office and on our website and provide it upon request. We will update this Notice when our privacy practices materially change.

For the Office of:

_____

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

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OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____