Kuljic DDS & Team
Center for Integrative Dentistry

NOTICE OF PRIVACY PRACTICES

Kuljic DDS & Team
900 Cummings Center, Suite 106T
Beverly, MA 01915
(978) 922-4200 | patient@kuljic.com

Effective Date: February 20, 2026

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

OUR LEGAL DUTIES

Kuljic DDS & Team ("the Practice," "we," "us," or "our") is required by law to:

- Maintain the privacy and security of your Protected Health Information (PHI)
- Provide you with this Notice explaining our legal duties and privacy practices
- Follow the terms of this Notice currently in effect
- Notify you promptly if a breach occurs that may compromise your information
- Comply with applicable federal and Massachusetts privacy laws

Protected Health Information includes information that identifies you and relates to your past, present, or future physical or mental health, treatment, or payment for care.

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

For Treatment

We may use and share your information to provide, coordinate, or manage your dental care.

Examples include:

- Exams, diagnosis, and treatment
- Consultations with specialists
- Prescriptions and lab services
- Referrals to other providers
- Communication with healthcare professionals involved in your care

---

For Payment

We may use and disclose your information to bill and receive payment for services.

Examples include:

- Submitting claims to insurance companies
- Verifying coverage and benefits
- Billing you or responsible parties
- Collection activities when necessary

For Healthcare Operations

We may use your information for practice operations, including:

- Quality improvement activities
- Staff training and supervision
- Licensing, credentialing, and compliance
- Business management and administrative functions
- Appointment reminders and treatment communications
- Customer service activities

OTHER PERMITTED USES AND DISCLOSURES

We may also use or disclose your information when permitted or required by law, including:

- Public health activities
- Health oversight and audits
- Court orders, subpoenas, or legal proceedings
- Law enforcement purposes
- Workers' compensation claims
- To prevent or lessen a serious threat to health or safety
- Organ donation purposes
- Military or national security purposes, if applicable

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

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

- Marketing purposes (unless allowed by law)
- Sale of your health information
- Most uses of psychotherapy notes (if applicable)
- Publication of identifiable photos, testimonials, or case information
- Any purpose not described in this Notice

You may revoke your authorization at any time in writing.

FUNDRAISING COMMUNICATIONS

We may contact you regarding fundraising activities related to the Practice. You have the right to opt out of receiving such communications.

MINIMUM NECESSARY STANDARD

When using or disclosing your information, we will make reasonable efforts to limit information to the minimum necessary to accomplish the intended purpose, as required by law.

SUBSTANCE USE DISORDER INFORMATION

SPECIAL CONFIDENTIALITY PROTECTIONS (42 CFR PART 2)

Certain information related to substance use disorder (SUD) diagnosis, treatment, or referral is protected by additional federal laws.

When applicable:

- SUD information receives heightened privacy protection
- Disclosure may require your specific written consent
- Redisclosure may be prohibited without additional authorization
- You may revoke consent at any time (except where action has already been taken)

Permitted disclosures without additional consent may include:

- Medical emergencies
- Treatment, payment, and operations when allowed by law
- Public health reporting requirements or other disclosures specifically permitted by federal regulations

ELECTRONIC COMMUNICATIONS

We may communicate with you electronically, including:

- Email
- Text messages
- Patient portal messages
- Online forms

While we use reasonable safeguards, electronic communication may carry some privacy risks. You may request alternative methods of communication at any time.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

Access and Copies

Inspect and obtain copies of your records, with limited exceptions.

Amendments

Request corrections to your information if you believe it is incorrect or incomplete.

Restrictions

Request limits on how your information is used or disclosed.
We are not required to agree, except as described below.

Confidential Communications

Request communications by alternative means or locations (for example, mail instead of email).

Out-of-Pocket Payment Restriction

If you pay for a service in full out-of-pocket, you may request that we not disclose information about that service to your health plan. We will honor this request unless disclosure is required by law.

Accounting of Disclosures

Receive a list of certain disclosures made outside of treatment, payment, and operations.

Paper Copy of This Notice

Receive a paper copy at any time, even if you agreed to electronic delivery.

Personal Representatives

Your authorized representative may exercise your rights on your behalf.

MINORS

Parents or legal guardians generally have access to their child's records, except in circumstances where the law allows minors to consent to their own care.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time.
Changes will apply to all information we maintain.

The current version will be:

- Posted in our office
- Available on our website
- Provided upon request

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint without fear of retaliation.

Contact Our Privacy Officer

Privacy Officer — Kuljic DDS & Team
900 Cummings Center, Suite 106T
Beverly, MA 01915
Phone: (978) 922-4200
Email: patient@kuljic.com

You may also file a complaint with:

U.S. Department of Health and Human Services
Office for Civil Rights (OCR)
https://www.hhs.gov/ocr/privacy/hipaa/complaints/

PATIENT ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices for Kuljic DDS & Team.

Patient Name: _____ Signature:_____Date:_____

(If signed by a personal representative) Name:_____Relationship:_____ Date:_____