

PRIVACY NOTICE

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. SIGN & DATE THE SECOND PAGE.

Your protected health information (i.e.; individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e.; your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e.; to determine the results of cleanings, surgery etc.)
- To third party payers or spouses (i.e.; insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e.; to determine benefits, dates of payment, etc.)
- To certifying, licensing, and accrediting bodies (i.e.; the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure, or accreditation
- Internally, to all staff members who have a roll in your treatment
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To you family and close friends involved in your treatment
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules you have the right to:

- Request restrictions on the use and disclosure of your protected health information
- Request confidential communication of your protected health information
- Inspect and obtain copies of your protected health information through asking us
- Amend or modify your protected health information in certain circumstances
- Receive an accounting of certain disclosures made by us of your protected health information
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or to the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation)

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information
- To abide by the terms of our Privacy Notice that is currently in effect
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e.; individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e.; performance reviews, certification, accreditation and licensure).

You have the right to review our office’s privacy notice prior to signing this consent, a copy of which was given to you with this consent.

You have the right to request restrictions of the use of your protected health information. However we are not required to, and may not, honor your request.

We may amend the attached privacy notice at anytime. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this consent at any time in writing. However, such a revocation will not be effective to the extent that any action is taken in reliance on this consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient/Guardian Signature

Print Name

Date