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.

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 or 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 any role in your treatment.
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about the 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 and modify your protected health information in certain circumstances.
- Receive an accounting or certain disclosures made by us of your protected health information, and
- 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 as our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of 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 the protected health information.

Please note that we are not obligated to:

- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. IF you have any questions about the information in this Notice, please ask our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

****Security Cameras onsite are for afterhours building security only. We do not film/record during business hours of patient care for privacy reasons.****

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have read this Privacy Notice. (A copy can be provided upon request.)

PRIVACY AUTHORIZATION

This authorization is required by the privacy regulations recently promulgated by the United States Department of Health and Human Services.

Your protected health information, including individually identifiable information, such as names, dates, photographs, x-rays, study models and letters. You may have written regarding your experience in this office will be used or disclosed for the purpose of:

Lectures/Presentations **Practice Marketing**

Demonstrate types of treatment results

This information will be disclosed by the member of the staff involved in the given activity. The information will be disclosed to those who could benefit from the information.

You have the right to revoke this authorization at any time in writing. However, your revocation will not be effective to the extent that this authorization has been relied on. This information used or disclosed per this authorization may be subject to re-disclosure by the recipient(s), and thus no longer protected by the privacy rules.

The following lists of people are granted permission to discuss, schedule appointments, or review any and all account or treatment information.

_____ _____

_____ _____

_____

Patient Name (Please Print)

_____ _____

Patient Signature (Parent/Guardian) Relationship to Patient