

## NOTICE OF PRIVACY PRACTICES

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.

### Uses and disclosures of health information

We use and disclose health information about you for treatment, payment and healthcare operations. Your protected health information (i.e., individually identifiable information, such as medical and dental histories, 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:

- Treatment- To other health care providers (i.e., your physician, general dentist, oral surgeon, periodontist, etc.) in connection with our rendering orthodontic treatment to you; Referrals may be sent electronically via email;
- Payment-To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment for services we provide to you (i.e. to determine benefits, dates of payment, etc.); Insurance claims may be sent electronically via email;
- Healthcare Operations-To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontists, 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 (such as email, text messages, voicemail messages, postcards, or letters) or information about treatment alternatives or other health related benefits and services that may be of interest to you.
- There are additional situations when we are required to use or disclose your protected health information without your consent or authorization (i.e. reporting to law enforcement officials, government agencies, Judicial and Administrative Proceedings, for public health activities, research, workers compensations, or to avoid a serious threat to health or safety).

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.

**Patient rights** - Under the new privacy rules, you have the right to:

- Request restrictions (in writing) on the use and disclosure of your protected health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency)
- Request confidential communication of your protected health information;

- Inspect and obtain copies of your 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. This accounting will not include disclosures of health information that we made for purposes of treatment, payment or health care operations pursuant to a written authorization that you have signed.
- You may, without the 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 the United States of Health and Human Services (which must be filed within 180 days of the violation).

**Our legal duty** - 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.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- 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 on the acknowledgement of receipt of this notice. If you have any questions about the information in this notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

**PATIENT ACKNOWLEDGMENT**

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

\_\_\_\_\_  
Signature of Patient/Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Please print name

If unable to sign please state reason:

\_\_\_\_\_  
\_\_\_\_\_