NOTICE OF PRIVACY PRACTICES

You have certain rights regarding your protected health information (PHI). These rights are given to you under the Health Information Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please note, we reserve the right to change the terms of this notice from time to time and you may contact us at any time to obtain the most current copy of this notice. Please review this notice carefully, the privacy of your health information is important to us.

Collecting Protected Health Information (PHI): We will only request personal information needed to provide our standard of quality Orthodontic care, implement payment activities, conduct normal Orthodontic practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Uses and Disclosures of Protected Health Information (PHI): This office uses and discloses health information about you and/or family members for purposes of treatment, payment, and Orthodontic practice operations. For example:

> **Treatment:** We use and share your PHI to provide care and other services to you--for example, to diagnose and treat your dental condition. In addition, we may contact you to provide appointment reminders or information about treatment options. We may tell you about other health-related benefits and services that might interest you. We may also share PHI with other dental specialists, dentists, hygienists, assistants, and others involved in your care.
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> **Payment:** We may use and share your PHI to receive payment for services that we provide to you. For example, we may share your PHI to request and receive payment from your health insurer or other company or program that arranges or pays the cost of some or all of your dental care ("Your Payor") and to confirm that Your Payor will pay for dental care. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for your Treatment, such as your spouse or parent.
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> **Practice Operations:** We may use and disclose your health information in conjunction with our health care operations, which include quality assessment and improvement activities, reviewing the competence or qualifications of personnel who work in this office, evaluation performance, conducting training programs within the office, accreditation, certification, licensing, or credentialing activities. Your health information may also be disclosed to our attorneys, consultants, law enforcement and government officials as necessary and required by law to respond to any type of investigation or legal action pertaining, but not limited, to the quality of treatment provided to you.

In addition to our use of your health information for treatment, payment, or Orthodontic practice operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us such an authorization, you have the right to revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. You may also request that we place additional restrictions on our use of disclosure of your Orthodontic health information. We reserve the right to discuss your request and we are not required to agree to your additional restrictions. If we agree to abide by your request, however, we may be exempted from this agreement in the event of an emergency.

Patient Rights: You have a right to request copies of your healthcare information; to require copies in a variety of formats. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately.

I have reviewed the above information and understand that by signing this Consent form, I am giving my consent to the office's use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Name: ____

Patient/Parent/Guardian Signature: ____ Date: ____________________