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.

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

- To other healthcare providers (i.e., your orthodontist, oral surgeon, etc.) in connection with our rendering dental treatment to you (i.e., to determine the results of surgery, orthodontic treatment, etc.).
- To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to assist you to obtain payment (i.e., to determine benefits, dates of payment, etc.)
- To certifying, licensing and accrediting bodies (i.e., the American Dental Association, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all team members who have any role in your treatment;
- To a family member or friend that you agree to have involved;
- 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.
- Although we do everything we can to protect your privacy, please understand that other patients or third parties may overhear incidental information about treatment or scheduling. Rest assured that we will do our absolute best to protect 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 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; 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, Laura Bell, RDH at our address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

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 for our Privacy Contact Person, Laura Bell, RDH, 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.

____ Date ______________

Signature of Patient, or parent/guardian if patient is a child