

## **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 address, home address, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following aspects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with your 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 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 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; 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 at our office address) or 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; and,
- 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 your 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.

☐ YES ☐ NO I agree to allow photos/videos of my child/children/self in group events, to be posted on Larson Orthodontics social networking sites. (If NO please be aware when attending our events, that photos and videos will be taken.)

Our office uses an encrypted texting service and will use that service to communicate with you regarding your treatment plan, financial arrangements, etc. 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 or direct your questions to this person at our office address. Thank you.

**PATIENT ACKNOWLEDGEMENT**

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

Parent

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Patient Signature

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Date