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PRIVACY CONSENT

This form is required by the new patient privacy regulations recently issued by the United States Department of Health and Human Services. Prior to commencing your orthodontic treatment, you must review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses and demographic data) may be used in connection with your treatment, payment of your account or health care operations. You have the right to request restrictions on the use of your protected health information.

Our office is only able to have one party held responsible for the account.

We can only release information regarding the account to the responsible party. If it is necessary for you to have another party involved, it is up to the responsible party to share any information regarding the account.

We will be happy to file insurance that is through another party. We must have a completed claim form with the insured's signature and the responsible party's signature allowing us to disclose information to the insurance company and the insured's signature for authorization of payment.

Please be aware that we can only release information regarding the insurance to the insured.

This signed form will allow us to leave appointment information, financial information or anything that might be pertinent to the patient on your cell phone.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice. You may revoke this consent at any time in writing.

Thank you for your cooperation. Please let us know if you have any questions.

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Print Patient Name Date

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Patient-Parent-Guardian (Signature)

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Patient- Parent- Guardian (Print)

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