PRIVACY CONSENT NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PRIOR TO COMMENCING YOUR ORTHODONTIC TREATMENT, PLEASE REVIEW, SIGN, AND DATE THIS FORM.

Your protected health information (i.e., individually identifiable information, such as 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:

- To other health care providers (i.e., your general dentist, oral surgeon, our internal staff, etc.) who have any role in your treatment
- 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 of your account (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;
- 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, however we are not required to, and may not honor your request.
- Request confidential communication of your protected health information;
- Amend or modify your protected health information in certain circumstances (unless it is accurate and complete).
- 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).

This privacy notice is effective as of the date of your signature. Thank you for your cooperation. Please let us know if you have any questions.

PATIENT ACKNOWLEDGMENT

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

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Patient (If minor, Guardian Signature) Date