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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 addresses, social security numbers, and demographic data) may be disclosed by us in one or more of the following respects: To other healthcare providers, (i.e. your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e. to determine the result of cleaning, surgery, etc.
- 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 (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 a role on your treatment.
- To other patients and third parties who see or overhear incidental disclosures about your treatment, scheduling etc.
- To your family and close friends involved in your treatment.
- 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 of disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.
- 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.

__________________________ _____________
Patient (or responsible party) **(Date**