



ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES

If you are 18 years of age or older, we will only discuss treatment and/or financials with the patient due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) law. You may provide written authorization for friends and/or family (this includes immediate family) to change your appointments, cancel appointments, confirm appointments, make a payment or check information in regards to your treatment and account.

I acknowledge that video surveillance is conducted on the premises of San Marcos Orthodontics. I understand that this video surveillance is conducted in all dental treatment areas, business areas, and children's play areas only at present. San Marcos Orthodontics retains ownership of video surveillance records as permanent records and does not include transfer of this video recording when transferring dental records to any other medical or dental provider, insurance company, or to parent/legal guardian. This video surveillance may be viewed and monitored at any time by authorized persons for the purpose of staff training, verification of compliance with employment policies of San Marcos Orthodontics, for purposes of legal proceedings, or to investigate misconduct.

Please list below anyone you would like to have the ability to call our office in regards to the patient's treatment, appointments, and account:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

****See Other Side****

SAN MARCOS ORTHODONTICS GROUP

HIPAA 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 addresses, home addresses, social security numbers and demographic date) 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, etc.) in connection with our 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 payments, 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; or use in studies, research, and educational presentations.;
- Internally, to all staff members who have any role in your treatment: to display patient names and/or photographs on bulletin boards, monitors, and our website.;
- 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;
- We may contact you via Text-message, E-mail, or Phone Call to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you prefer not to receive correspondence in one of these ways, you may provide us a written statement requesting that contact method be stopped.

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;
- 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 filled within 180 days of the violation).

We have the following duties under the privacy rule:

- By law, to maintain 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;
- 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, 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;
- 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.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in the 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 Name: _____ **Date** _____

Patient or Guardian Signature _____

****See Other Side****