



Patient Privacy Consent

Patient's Name: _____

Case # _____

- It is our policy to comply with federal and state regulations with regard to patient privacy. We will protect your privacy in our communications with you, your family dentist, other health care professionals that we work with who are treating you, your insurance companies, third party financing companies, and whomever we mutually work with to provide you with the highest level of care.
- When this patient's information is sent electronically or by mail, we will do all that is reasonably possible to make sure that it is only sent to associated health care professionals or to specific individuals involved in electronic processing of insurance claims. When sent, we will do all that is reasonably possible to make sure that only the minimal information is sent.
- We will use the patient's health history, initial interview, doctor exam and initial diagnostic records to understand the patient's present state of health, to determine the patient's sensitivity to various materials, drugs and the environment, to help diagnose the patient's orthodontic and oral-facial problems, and to refer back to as treatment progresses.
- During treatment, we will be sending this patient's primary dentist copies of the progress reports we give to you. When necessary, we will be sending related health care professionals records with requests for treatment (for example, general dental, periodontal, endodontic, etc., treatment, tooth removal, oral-facial surgery, etc., including possible physician referrals if the patient is presently under a physician's care).
- When communicating with you about problems or complications in treatment, we will make every reasonable effort to do it in a private area of the office.
- When communicating with third party financing, including your orthodontic insurance companies and other third party payers (bank loans, credit cards, etc.) we will make every reasonable effort to provide them with the *minimal* information required to help you finance your treatment. In many cases, you will provide the information instead of us.
- We will only obtain a credit report on this patient's guarantor if allowed to do so; the purpose of the credit report is to allow us to offer you the best possible financial agreement to pay for your treatment.
- This patient's hardcopy records and diagnostic records will be filed in this patient's records folder, or when electronically filed, it will be filed in a password-protected computer system. We will do all that is reasonably possible to make sure that this information is only accessible to the doctors and team members who use that information in the care of this patient.
- Those with access to this patient's records are: the patient, custodial parent or legal guardian and in the case of divorce to the non-custodial parent with proper identification. There will be a fee to duplicate this patient's records.
- A copy of this policy will be kept on file should you require a copy at any time. If policies change, you will be notified of the changes.
- You have the right to revoke your consent in writing at any time, but this will not affect what has occurred before that revocation.
- You have the right to read the *entire* "Notice of Privacy Practices" before signing this consent form if you desire.

I am the <input type="checkbox"/> patient <input type="checkbox"/> custodial parent of this patient, <input type="checkbox"/> legal guardian of this patient: _____			
Signature: _____		Date: _____	
As the GUARANTOR of this patient's account, I consent to this practice obtaining a Credit Report on me.	Initial if yes: _____	I consent to this practice sending periodic reports and notifications to this patient's dentist and physician as needed for the proper care of this patient.	Initial if yes: _____
I consent to this practice providing my insurance company with necessary records in order to obtain payment for orthodontic treatment.	Initial if yes: _____	I consent to this practice using this patient's diagnostic and other records (excluding the medical history) for educational purposes or for Orthodontic Board cases.	Initial if yes: _____
I consent to this practice providing a 3 rd party payer (bank, OFP, etc.) with the required information for financing all or part of this patient's treatment.	Initial if yes: _____	I consent to this practice displaying photographs of this patient on computer displays and on office bulletin boards or in office photo albums and newsletters.	Initial if yes: _____

Witnessed:

Signature: _____ Position: _____

Date: _____