



## Acknowledgement of Notice of Privacy Practices

This notice describes how your health information may be used, disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us. This notice takes effect on date of the first office visit and will remain in effect until we replace it. For more information about our privacy practices or additional copies of this notice, please contact us.

### Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and health care operations. For example:

#### **Treatment**

We disclose dental information to our employees, family, friends and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

#### **Payment**

We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

#### **Health Care Operations**

We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

#### **Your Authorization**

In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice

#### **Unsecured Email/Text**

We will not send you unsecured emails pertaining to your health information. If you text doctors through private messaging for advice or communication that is not HIPPA protected.

**Required by Law**

We may use or disclose your health information when we are required to do so by law.

**Persons Involved in Care**

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or your death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays or other similar forms of health information.

**Marketing Health-Related Services**

We may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested.

**Appointment Reminders**

We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

**Sign-In Sheet and Announcement:**

Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

**Research and Presentations**

Your health information may be disclosed to researchers for research and presentations purposes.

**Breach Notification**

In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

I, \_\_\_\_\_ [full name], have received a copy of Notice of Privacy Practices.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

**Personal Representative's name** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

Smile Power Orthodontics [www.smilepowerorthodontics.com](http://www.smilepowerorthodontics.com)

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