

I authorize my insurance to pay directly to my dentist if my dentist is a participating provider. If I am covered by any other plan, I will pay in full when services are rendered. I understand that all policies are different and I am responsible for knowing my plan provisions. I will be responsible for all co-payment, deductible and rejected charges.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Notice of Privacy Practices- HIPPA

### Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. We may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use your child's health information for marketing purposes. If we suspect a possible victim of abuse, neglect or domestic violence we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards, emails or letters).

### Patients Rights

**Access:** You have legal right to look at or get copies of you health information. If you request copies we will charge you for each page for staff time to locate and copy the information and postage if you want the copies mailed.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of information.

**Alternative Communication:** You have the right to request that we communicate with you about your health history in alternative means.

**Amendment:** You have the right to request that we amend your health information. We may deny your request under certain circumstances.

### Question and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information, you may submit a written complain to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact Dr. Harmon or Dr. Owensby.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_