PRIVACY NOTICE

Healthcare Insurance Portability
And Accountability Act (HIPAA)

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, e-mail addresses, home addresses, social security numbers. and demographic data) may be used or disclosed by us in one or more of the following respects:

- Treatment: 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.);
- Payment: 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 payment, etc.);
- Healthcare Operations (i.e. quality assessment and improvement activities, licensing and accrediting bodies)
- Internally to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- Individuals Involved in Your Care or Payment for Your Care: (i.e. your family and/or close friends)
- Disaster Relief
- Required by Law
- Public Health Activities: (i.e. prevent or control disease, injury or disability)
- National Security
- Secretary of Human Health Services
- Worker's Compensation
- Law Enforcement
- Health Oversight Activities
- Judicial and Administrative Proceedings
- Research
- Coroners, Medical Examiners, and Funeral Directors
- Fundraising
- 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.

Our office may transmit your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers. and demographic data) electronically in one or more of the respects as stated above.

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 (submit your request in writing):

- 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; and
- You may without the risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquires to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Service, (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the 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 so, 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 of disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- 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 this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

23 John Maddox Drive NW
Rome, Georgia 30165
706 234-0877 706 232-5327(f)
E-Mail: drryancox@gmail.com

PRIVACY CONSENT

We are required by applicable federal and state law to maintain the on. We are also required to give you this Notice about our privacy practices, your protected health information. We must follow the privacy practices that are Prior to commencing your orthodontic treatment you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information; however, we are not required to, and may not, honor your request.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may revoke this Consent at any time in writing; however, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient Signature (Parent/Guardian if Patient is a Minor)	Print Name	Date

CONSENT TO CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize Pridemore Cox Orthodontics to share any and all of my medical / billing information with the following people:

Name	Relationship	Phone #	Initials
Name	Relationship	Phone #	Initials
Name	Relationship	Phone #	Initials