CROCK
ORTHODONTICS

HIPAA Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Crock Orthodontics respects you and your privacy. We are committed to keeping all information received or created confidential. This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out services, work with insurance companies, and other purposes required/permitted by law.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of any changes to the privacy practices with respect to your PHI.

How Your Protected Health Information May Be Used or Disclosed
Crock Orthodontics uses protected health information about you for services, payment, and coordination of dental care. We do not require authorization to use your protected health information for these purposes. Following are some examples of how the information may be used.

Treatment:
Providing services related to your dental health, such as working with other dentists or physicians may require us to exchange information for the purposes of coordinating services.

Payment:
Information needed for billing, insurance, or compensation for services, if necessary, may be exchanged with the billing department or dental insurance companies.

Healthcare Operations:
We may disclose or use protected health information as needed to support the business activities of the office. For example, quality assurance or employee review activities. Protected health information will not be used for marketing purposes without written permission of the patient/parent.

Emergency Care:
Protected health information may be exchanged with appropriate professionals in an emergency.

When Legally Necessary:
As required by federal, state, or local law, we may make disclosures when a law requires that we report information. Examples include reporting about victims of abuse or neglect, threats to personal or public safety, or criminal activity.

Your Rights
You have the right to inspect and obtain a copy of your health information. You have the right to request certain restrictions on the use or disclosure of your protected health information. We are not required to agree to the requested restriction. You also have the right to request that we amend the information, but the information can only be amended by Crock Orthodontics. You have the right to receive confidential communications of protected health information and you may designate how that information is sent to you. You have a right to a paper copy of this Notice of Privacy Practices. You have the right to complain to the Department of Health and Human Services Office for Civil Rights if you think your privacy rights have been violated, with no punishment for doing so.

If you have any questions, contact Kathy Williams, HIPAA Compliance Coordinator at Crock Orthodontics. This notice became effective on April 14, 2003.

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act.) I understand that by signing this consent, I authorize Crock Orthodontics to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e., my dental and/or medical insurance company/companies
- The day-to-day healthcare operations of your dental practice

Additionally, I authorize you to share all my protected healthcare information with the following individual(s):

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature:	Date:

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form:			
Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date: