

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Visit: _____

My signature on this form acknowledges that I have received a copy of Wilke Orthodontics, Ltd.'s Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Wilke Orthodontics, Ltd., and of my rights with respect to my health information.

By signing this form, I consent to Wilke Orthodontics' use of my patient health information to carry out treatment, payment activities, and health care operations as set forth in their Notice of Privacy Practices.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

Patient's Signature Date

Signature of Patient's Representative Date
(if patient is a minor or unable to sign)

I hereby give consent to Wilke Orthodontics, Ltd. to give my patient health information to:

Print Name and Relationship to Patient Date

Print Name and Relationship to Patient Date

Print Name and Relationship to Patient Date

This consent is effective until revoked by me. I may revoke this consent at any time by giving written notice of revocation to Wilke Orthodontics, Ltd. Revocation of this consent will not affect any action Wilke Orthodontics, Ltd. took in reliance on this authorization before receiving written notice of revocation. Treatment may be declined or discontinued if consent is revoked.

To be completed by Wilke Orthodontics, Ltd., if form is not signed:

1. Was the patient/representative provided with a copy of the Notice of Privacy Practices? Yes No

2. Briefly describe the efforts made to obtain the patient/representative's acknowledgement of receipt of the Notice and explain why the patient/representative was not able or unwilling to sign this form:



PRIVACY NOTICE

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, email addresses, home addresses, social security numbers) may only be used or disclosed by us in one or more of the following respects:

- 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.);
- To third party payors 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.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients & third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment, with your permission;
- We may contact you (via voicemail, e-mail, letters or text messages) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you; and,
- Other government agencies as required by law.

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. A new privacy notice must be updated at age 18. Should this take place during treatment, please contact us.

Under the privacy rules, you have the right to:

- 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;
- Request an alternate means or location for patient communication. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Officer at our office address) or the United States Secretary of Health and Human Services (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 or 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 November 1, 2011. If you have any questions about the information in this Notice, please contact our Office Administrator, Melody Dolan, or our privacy officer, Cynthia Tourmo at (920) 347-4565.

