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.

Kristin N. Moore D.M.D., M.S. & staff are committed to treating and using your protected health information in a responsible manner consistent with both state and federal regulations. Each time you are seen by our office, information about your visit is recorded in your orthodontic records. The records typically describe symptoms, diagnoses, test results, and treatment plans as it relates to your condition. Your orthodontic record is considered to be a legal document that describes the care you received. This information is the means by which you or a third party payor can verify that services were provided. Some or all of your medical information may be used in communications between health professionals or pharmacies, laboratories, etc. who contribute to your care and a coordinated treatment plan. We require all of those organizations to maintain the same level of confidentiality as we do. As such, we may use and disclose your health information only for each of the following purposes:

- ***Treatment*** means providing, coordinating or managing health care services
- ***Payment*** means activities related to obtaining reimbursement or confirming insurance coverage for services.
- ***Health Care Operations*** involves the business of running our practice in order to provide you with quality service.

Your medical privacy is extremely important to us and unless you authorize us in writing, your medical information is confidential to everyone. You have the right to obtain a copy of your orthodontic record and this notice as provided.

I hereby acknowledge that I have received and reviewed a copy of the Privacy Notice and that I understand how my personal health information can be disclosed.

Patient Name:_____ Date:_____

Patient (or Parent if minor) Signature:_____

Relationship to patient:_____

SIGNATURE ON FILE

I have been informed of the treatment plan and the associated fees. I request that payment of authorized insurance benefits be made either to me or my balance to Kristin N. Moore D.M.D., M.S. I authorize any hold of medical information about me to be released in accordance with HIPAA regulations to determine benefits or the benefits payable to related services. I understand my signature authorizes the release of medical information necessary to pay the claim as well as requesting payment be made. If other health insurance is indicated on the approved claim forms, my signature authorizes releasing of information to the insurer or agency shown. It is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill and any remaining balances after insurance payment is received or if the service is not covered under my orthodontic benefit plan.

I understand that I have the right to revoke your authorization to use my health information except in cases that action has already been taken.

Patient Name:_____ Date:_____

Patient (or Parent if minor) Signature:_____

Relationship to patient:_____

Internal Use Only:
If patient or patient's representative refuses to sign this acknowledgement or receipt of notice, document the date & time the notice was presented and sign below.

Presented on (Date/Time):_____

Presented by (Signed Name/Title):_____