HIP AA
(Health Insurance Portability Accountability Act)
Notice of Privacy Practices

1. **To Provide Treatment** — We will use your health information you provide within our office to give the best dental care as possible. This may include sharing your information with referring dentists, physicians, pharmacies, clinical and dental laboratories or other health care personnel rendering treatment.

2. **To Obtain Payment** — A written invoice stating dental treatment performed will be sent to your insurance company and provided to you as well. This will include all services rendered in order to collect payment.

3. **Abuse or Neglect** — Government authorities will be notified if we believe a patient is the victim of abuse, domestic violence or neglect. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically or authorized by law or with the patient's agreement.

4. **Friends, Family or Caregiver's** — We will share your information with only those friends, family, or caregiver's when informed by you, the patient. This includes medications, treatment needed/performed and payment history. Written permission will be needed before disclosing any information.

5. **Communication and Appointments** — It has always been our courtesy to remind patients of upcoming appointments. This has included post cards/confirmation calls. By marking the appropriate line, you will let us know if you wish to continue to receive reminders or not.

______ Yes, I do wish to continue to receive postcard/confirmation calls

______ No, I would prefer not to receive postcards/confirmation calls

Thank you for taking the time to review the latest HIPAA regulations. Please sign the bottom of this form so we may keep it part of your record. If you would like a copy of this, please let us know.

____ ____________________

Signature Date