webb ORTHODONTICS

Your Health. Your Smile. Your Orthodontist.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for the above named practice.

Printed Name of Patient: _____ Date of Birth: _____

_____ Date: _____

Signature of Patient/Parent/Guardian

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Printed Name of Patient: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sally Martin Phone: (704) 364-7343 Fax: (704) 364-2729
Address: 2915 Coltsgate Rd., Ste. 102, Charlotte, NC 28211 E-mail: info@webb-orthodontics.com

Video Addendum: This shall serve as notice that in order to provide a safer environment for your treatment, Webb Orthodontics has installed a video recording system to better document your interaction with our staff. The recordings of your interaction will be stored as a part of your electronic medical records and will be protected in the same manner as the remainder of your treatment records. All of our privacy policies detailed in our HIPAA Privacy Notice also applies to these recordings. Prior to our use of this system to record our interactions or your treatment we need your consent.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form, Notice of Privacy Practices and Video Recording Addendum. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations and to record all interactions at the office.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Print Name