

# WEST BROOK ORTHODONTIC CENTER

## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers, e.g. insurance companies.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review the WEST BROOK ORTHODONTIC CENTER'S *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may refuse to sign this acknowledgement. I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke the consent, in writing, at any time, except to the extent that you have taken action relying on the consent.

**Patient Name:** \_\_\_\_\_

**Responsible Party Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If there is anyone with whom you want us to share treatment or financial information (other than parent, guardian, or dentist) please provide their names and phone numbers below.

			FINANCIAL	TREATMENT
Name: _____	Relationship: _____	#: (____) ____ - _____	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____	Relationship: _____	#: (____) ____ - _____	<input type="checkbox"/>	<input type="checkbox"/>

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### FOR OFFICE USE ONLY

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We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

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

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