WONDER
FAMILY DENTAL & DENTURES

19410 8th Ave NE Suite 102 Poulsbo, WA 98370
Phone: (360) 779-1566 | Fax: (360) 779-6879

Notice of Privacy Policies (HIPAA)

Patient Name: _____ DOB: _____

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the state of Washington. This includes issues relating to your treatment, payment, and our dental care operations. ***Your personal health information will never be otherwise given to anyone - even family members - without your written consent.*** You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secured from unauthorized access and our employees are trained to make certain that the confidentiality of your records are always protected. Our privacy policy and practices apply to all former, current, and future patients, so ***you can be confident that your protected health information will never be improperly disclosed or released.***

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, insurance information, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

As stated above, we may disclose information as required by law. ***We are obligated to provide information to law enforcement and governmental officials under certain circumstances.*** We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

You have the right to request copies of your health care information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. ***All such requests must be in writing.*** We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S.Department of Health and Human Services.

We thank you for being a valuable patient at Wonder Family Dental & Dentures. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Wonder Family Dental & Dentures. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Wonder Family Dental & Dentures reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

☐ ANY MEMBER OF THE FAMILY

☐ SPOUSE ONLY

☐ OTHERS (Please specify) _____

Patient/Parent/Guardian Signature: _____ Date: _____