

STATEMENT OF PRIVACY PRACTICES

Northwest Pediatric Dentistry
1200 112th Ave NE, Suite#B275
Bellevue, WA 98004
425.289.1918

We, at Northwest Pediatric Dentistry, are 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.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Healthcare Insurance Portability and Accountability Act 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 other family members – without your consent. You, of course, may give written authorization for Northwest Pediatric Dentistry to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is 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.

Collecting Protected Health Information

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, 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.

Disclosure Of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government 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, electronic mail, and postcards.

Patient Rights

You have a right to request copies of your healthcare 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 you 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 patient of Northwest Pediatric Dentistry. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for NW Pediatric Dentistry. 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 the office's 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.

NW Pediatric Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the 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.

Additional Disclosure Authority

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

ANY MEMBER OF MY IMMEDIATE FAMILY **YES** **NO**

SPOUSE ONLY **YES** **NO**

OTHER (PLEASE SPECIFY) **YES** **NO**

Name of Patient

Signature of Patient or Representative

Date

Relationship to Patient

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement Not Obtained

Provided Prior to Treatment **YES** **NO** **Date Provided:** / /

Reason For Denial:

- Needed more time to review Statement of Privacy Practices**
- Wanted to consult with another person before signing**
- Unable to sign**
- Reason not given**
- Other (Explain):**