NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4 / 1 / 03 , and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family, Friends and Persons Involved in Care: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Court Orders and Subpoenas: We may disclose information in response to an appropriate court order or subpoena.

Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters). We may also contact you to provide information about treatment alternatives or other health-related information that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

Email: _____

Address: _____

_____

Central Florida Orthodontic Specialists

Altamonte Springs, Florida
990 N. State Road 434
Ste 1188
Altamonte Springs, FL 32714
Ph: (407) 682-0883

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1454 W. Int'l Speedway Blvd.
Daytona Beach, FL 32114
Ph: (386) 947-2063

Orange City, Florida
200 Treemonte Dr.
Orange City, FL 32763
Ph: (386) 775-8707

Winter Park, Florida
7534 University Blvd.
Winter Park, FL 32792
Ph: (407) 672-0030

Eustis, Florida
2900 David Walker Dr.
Eustis, FL 32726
Ph: (352) 589-5558c

LETTER OF INFORMATION AND CONSENT AGREEMENT

Orthodontic treatment is not an exact science. Like any treatment of the body, much of its success depends on the understanding and **cooperation of patients.** While recognizing the benefits of a pleasing smile and healthy functional teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has some hazards, inconveniences, and limitations. These drawbacks seldom outweigh the long-range benefits, but should be considered in making the decision to wear orthodontic appliances.

The following information is routinely supplied to anyone considering orthodontic treatment in our office. Please read through this form carefully and **ask the orthodontist/staff to explain anything you do not understand.** Clarify what is expected of you as a patient, or as a parent of a young patient, to achieve excellent results.

Perfection is always our goal. The Orthodontist will use his / her knowledge, training, skill and experience (three extra years of orthodontic specialty training are required by the American Dental Association before one can be called an orthodontist) to achieve perfect function that is also aesthetically pleasing. **Much depends on the patient's growth patterns, genetics, oral health, and cooperation.**

Throughout life, tooth positions are constantly changing. This is true with all individuals regardless of whether they have worn braces or not. After orthodontic treatment, patients are subject to the same subtle changes that occur in non-orthodontic patients. In the late teens and early twenties, orthodontic patients may notice slight irregularities developing in their front teeth. This is particular true if their teeth were extremely crowded prior to treatment.
Prolonged wearing of retainers may be the only way to prevent this if it becomes undesirable.

Orthodontic appliances do not cause cavities. They may trap particles and increase the likelihood of a patient developing cavities or decalcification marks. Decalcification (permanent marking on the teeth), tooth decay, or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. **Patients are able to prevent these problems with a combination of a proper diet, good tooth brushing habits, and regular checkups with the dentist.** Sugar and between-meal snacks should be eliminated. Occasionally, periodontal (gum) problems present before orthodontic treatment may be worsened by wearing braces and may require treatment by another specialist.

Cold sores, canker sores, and irritations or injury to the mouth are possible while wearing braces. Loose or broken wires and bands can also scratch or irritate your cheeks, gums, or lips. Your orthodontist will give you soft wax to cover problem areas like this. Also allergic reactions to dental materials or medications are rare, but do occur occasionally.

Teeth must sometimes be extracted as part of the orthodontic procedure. Your orthodontist will recommend removal only if it improves your prospects for successful treatment. There may be a need for fillings, crowns, bridges, gum treatment or other dental procedures before, during orthodontic treatment. **On rare occasions the nerve of a tooth may become abscessed.** A tooth that has been irritated by a deep filling or even a minor blow may require treatment by another dentist. In some instances, the root ends are shortened during treatment. This process is called root resorption. Under healthy circumstances, the shortened roots are no disadvantage. There are rare circumstances that may lead to loss of teeth due to root resorption. There is no way to foresee whether this will happen, and nothing can be done to prevent this from occurring.

There is also a very small chance that pain may occur in the lower jaw joints, i.e. temporomandibular. Tooth alignment or bite correction can usually improve tooth-related causes of jaw discomfort, but additional treatment by another dentist may be required.

Occasionally, a person who has growth normally and in average proportion may not continue to do so. If growth becomes disproportioned, the jaw position can be affected and original treatment objectives may have to be compromised. Skeletal growth disharmony is a biological process beyond the Orthodontist's control. This disharmony may necessitate surgical correction in conjunction with orthodontics treatment.

Orthodontic treatment can only be successful if all parties are willing, and able to cooperate by wearing headgear, elastics, and retainers as instructed. **Otherwise the length of treatment may be extended or the results may be compromised.** We appreciate your confidence in selecting our office. We want you to be fully informed, so ask questions anytime. During the period of orthodontic treatment, we may make models, x-rays, and photographs which may be used for professional reference and display, orthodontic journals, books, meetings, and patient educations.

I have read and understand the letter of information and with this knowledge, consent to treatment for **{Patient First Name} {Patient Last Name}.**

Signature: _____ Relationship to patient: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name: First Name: _____ Last Name: _____
Responsible Party/Billing Party: First Name: _____ Last Name: _____
Address: _____
Telephone: _____ E-Mail: _____
Patient #: _____ Social Security: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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. A copy of our Notice accompanies this Consent. We encourage you to 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, including any revisions of our Notice, at any time by contacting:
Office Manager: Shelly Quates Phone: 407-672-0030 or E-Mail: winterpk@orthodon.com

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 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, **{Billing Party First Name} {Billing Party Last Name}**, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy. 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 our treatment, payment activities and healthcare operations.

Signature:_____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's
Name:_____ Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I revoked my Consent.
Signature:_____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient Name: _____

X_____
Signature Of Responsible Party

Date: _____

For Office Use Only

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

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____