Piedmont Family Dentistry
181 W. WILKES MEDICAL CENTER RD.
FERGUSON, NC 28624
336-973-5060

NOTICE OF PRIVACY PRACTICES

Your privacy is very important to us. We promise to take every precaution to protect your rights to having your health care information secure. Our formal notice of privacy practices is posted in the waiting area. Please read this while waiting for your visit. You may also request a copy of this notice from the receptionist.

We also need to ask our patients how they wish to be notified about upcoming appointments. Piedmont Family Dentistry may call my home to confirm upcoming appointments and may leave a message on my answering machine if I am not available. ____YES ____NO

I have read the posted notice and/or requested a copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at the address above to obtain a current copy of the policy.

PATIENT CONSENT

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

- Conduct, plan and direct my treatment and follow-up amount the multiple health care providers who may be involved in that treatment directly and indirectly.
- Contact third party payers such as an insurance company to verify benefits.
- Obtain payment from third party payers such as insurance companies.
- Conduct normal health care operations such as quality assessment and physician certifications.
- Contact me by phone for appointment reminders.

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 such 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 at the address above to obtain a current copy of the Notice of Privacy Practices.

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 this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME: _____

SIGNATURE: _____ DATE:_____/_____/_____
(Parent/Guardian if patient is a minor)