PATIENT DISCLOSURE STATEMENT

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner: (*check all that apply)*

_____Home Telephone _____ Cell Phone _____Work Phone

_____ I allow Fullerton Orthodontics to mail/email written communication to my home address

_____ I allow Fullerton Orthodontics to mail/email written communication to my work address

_____ I allow Fullerton Orthodontics to text/email appointment confirmations

_____ I allow Fullerton Orthodontics to text/email financial information

_____ I allow Fullerton Orthodontics to email/text work or school excuse

_____ I allow Fullerton Orthodontics to leave detailed messages

_____ I allow Fullerton Orthodontics to leave messages with call back number only

We use Tops DPX program to send confirmations via text. Message and data rates may apply. You may reply with STOP, HELP, or you can call our office at 936-756-1951. Text messaging opt-in data and consent will not be shared with third parties.

I acknowledge that I have read and filled out the following forms to the best of my ability:

Patient Information Form

Health History Form

Consent and Release of Records Authorization

Acknowledgement of Receipt of Privacy Practices Notice Patient Disclosure Instructions

_____ _____

Signature (Parent/Guardian if Minor) Date

Fullerton Orthodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this Notice of Privacy Practices and
(please print name)

_____

Signature (Parent/Guardian if Minor) Date

You may refuse to sign this acknowledgement.

I give my permission for Fullerton Orthodontics to discuss my/my child's treatment options or payment options with the following people:

_____

Please print name and relationship to patient Date

_____

Please print name and relationship to patient Date

_____

Please print name and relationship to patient Date

For Office Use Only

We attempted to obtain written acknowledgment 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)