ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE OF HEALTH INFORMATION

Practice Name: Thomas Orthodontics

Privacy Officer: Dr. Brian W. Thomas

Patient Name: _____

Patient DOB: _____

1. Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided a copy of the **Thomas Orthodontics Notice of Privacy Practices (NPP)**. I understand that the NPP describes how my health information may be used and disclosed, how I can access my information, and my rights regarding my privacy.

- I understand that a current copy of this Notice is available in the reception area and on the practice website.
- I understand that the Practice has the right to change the Notice of Privacy Practices at any time, and I may contact the Practice to obtain a current copy.

2. Florida Consent for Use and Disclosure (Treatment, Payment, Operations)

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and **Florida Statute § 456.057**, I have certain rights to privacy regarding my protected health information.

I hereby authorize and give my specific consent to Thomas Orthodontics to use and disclose my health information (including dental records, x-rays, and financial information) for the following purposes:

- **Treatment:** Providing orthodontic care, including sharing records with my general dentist, oral surgeons, or other specialists involved in my care.
- **Payment:** Submitting claims to my dental insurance company, verifying coverage, and billing for services.
- **Healthcare Operations:** Internal administration, quality assessment, and business management of the practice.

3. Open Bay Treatment Environment Acknowledgement

I understand that Thomas Orthodontics utilizes an **"Open Bay"** treatment area. This means that multiple chairs are located in a shared clinical space. I acknowledge that:

- While the Practice takes reasonable safeguards (such as lowered voices and spacing), my presence in the office and conversations regarding my treatment may be incidentally seen or overheard by other patients or parents in the bay.
- I have the right to request a **private room** for sensitive discussions or procedures if I choose.
- By proceeding with treatment in the open bay, I consent to these incidental disclosures.

4. Consent for Electronic Communications

I authorize Thomas Orthodontics to contact me regarding appointments, treatment progress, and account status via:

[ ] Text Message to: (____) -

[ ] Email to: _____

I understand that standard text messaging and non-secure email are not encrypted and carry some risk of being intercepted. By providing my number/email, I consent to receive unencrypted appointment reminders.

Signature of Patient or Personal Representative

Date

Relationship to Patient (if signed by parent/guardian)

FOR OFFICE USE ONLY

(Complete this section ONLY if the patient refuses to sign)

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): _____

Staff Member Name: _____

Date: _____