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 September 1, 2015, 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

Your health information and the rights associated with that health information also rest with the "personal representative" of that individual, generally the parent or legal guardian, if you are a minor.

We use and disclose health information 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 and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: 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, but only if you agree that we may do so.

Persons Involved In Care: 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. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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 officials 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).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of this Notice for a full explanation of time and fees involved.

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, costbased 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).

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, 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 anyway if you choose to file a complaint.
Contact Information: Georgia Orthodontics & Children's Dentistry
Telephone: 770-521-2100
Email: info@gaorthopedo.com
Address: 13075 Highway 9 N, STE 110, Milton, GA 30004

Authorization for additional disclosure: If the patient is a minor, I am the "personal representative" of (generally parent or legal guardian) and have legal authority to make health care decisions about the following minor patient:
Patient Name: _____ **Date:** _____
If the patient is a minor, as the "personal representative" of the above named patient, I authorize the following individuals to accompany my child and have access to health information. **Name & Relationship**

1. _____

2. _____

3._____

4. _____

I have read this document in its entirely and understand the provisions of HIPAA.

X

_____

Patient/Guardian Signature Date

GEORGIA
Orthodontics & Children's Dentistry

13075 Highway 9 N, STE 110
Milton, GA 30004
Phone: 770-521-2100
Fax: 404-469-0324
gaorthopedo.com

DATE:_____

Patient Information

Name _____ Nickname _____ Sex **M** **F**
Last First Middle

Address _____
Street City Zip

SS# _____ Age ____ Birthdate ____/____/____ School _____ Grade _____

Sports/Hobbies/Interests _____

Siblings _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middle

Address _____
Street City State ZIP

Home Phone _____ Cell Phone _____ Preferred Contact **Home** **Cell**

Email Address _____

Relationship to Patient _____ SS # _____ Occupation _____

Birthdate ____/____/____ Employer _____Work Phone _____

Marital Status **Single** **Married** **Divorced** **Adoptive Parent** **Foster Parent**

Significant Other's Name _____

Relationship to Patient_____ SS # _____ Occupation _____

Birthdate _____/_____/_____ Employer _____ Work Phone _____

Dental Insurance Information

Policy Owners Name _____ Policy Owner's SS# _____

Policy Owner's Birthdate _____/_____/_____ Relationship to Patient _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Company Address _____

Employers Address

_____

Do you have dual coverage? **YES** **NO** If Yes:

Policy Owners Name _____ Policy Owner's SS# _____

Policy Owner's Birthdate _____/_____/_____ Relationship to Patient _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Company Address _____

Employers Address

_____

Medical History

Has your child ever had any of the following conditions?

Y N Asthma/Lung Troubles

Y N Anemia

Y N Allergies to Drugs/Foods

Y N Austim/Asperger's

Y N Behavior Issues (ADD/ADHD)

Y N Blood Disorders

Y N Cancer

Y N Cong. Birth Defects

Y N Diabetes

Y N Disabilities/Special Needs

Y N Epilepsy or Seizures

Y N Hearing Impairment

Y N Heart Conditions/Murmur

Y N Hepatitis/HIV/AIDS

Y N Hospitalizations/ Surgeries

Y N Kidney/Liver Conditions

Y N Neurological Conditions

Y N Pregnancy

Y N Premature Birth

Y N Tuberculosis

If **YES**, please explain _____

_____

Please list any and all other medical conditions not mentioned above _____

_____

Please list all drugs/medications the child is currently taking _____

_____

Child's Physician _____ Phone Number _____

Address _____

Dental History

Is this your child's first visit to the dentist? **YES** or **NO**

If No, where and when was your child last seen? _____

Were any X-rays taken at previous dental visits? **YES** or **NO**

Has your child ever had a traumatic experience at the dental office? _____
Any questions or concerns about your child's teeth? _____
Any of the following habits?

Y N	Frequent snacking	**Y N**	Night-time feeding
Y N	Lip Sucking / Biting	**Y N**	Nail Biting
Y N	Sleeping with a bottle	**Y N**	Thumb/Finger Sucking
Y N	Tooth Grinding	**Y N**	Snoring
Y N	Sippy Cup Use	**Y N**	Pacifier Use

Does your child brush his/her own teeth? **YES NO**

How often? _____ x a day

Do you floss his/her teeth? **YES NO**

Is your child able to spit? **YES NO**

ACKNOWLEDGEMENT AND AUTHORITY

Since the child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before services can be rendered. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.
I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICE AND AGREE TO PAY FOR THEM, IN FULL, AT THE TIME OF SERVICE. I ALSO UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

_____

Signature of Parent or Guardian Date Relationship to Child

_____

Doctor Date

Photo Release Form

I, _____(please print), grant permission to Georgia Orthodontics & Children's Dentistry to use photographs taken of me, or members of my family, for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium.

I acknowledge that I am [ ] over the age of 18

[ ] the legal guardian of the following If

the legal guardian of patient, please list name(s) here:

Signature:

Date:

GEORGIA
Orthodontics &
Children's Dentistry