STATEMENT OF PRIVACY PRACTICES
Dr. Dona Seely

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us.
The commitment of each employee: To endure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices, but will always inform you to any changes that might affect your rights.

The Federal Health Care information Privacy Rule implement "HIPAA", the Health Insurance Portability and Accountability Act Of 1996, and compliance is mandatory beginning April 14, 2003. This notice describes how personal and medical information about you may be used and disclosed and how you and how you can access this information. Please read it carefully. You will be asked to sign a form that you have been informed of and acknowledge our Statement of Privacy Practices. This form will be kept in your chart.

Use and Disclosure of Protected Health Information (PHI): PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future condition and related health care services. Your PHI may be used and disclosed by Dr. Seely and her staff to others directly involved in your care and treatment for the purpose of providing dental services to you, to pay or directly involved in your care and treatment for the purpose of providing dental services to you, to pay or collect your dental bills, to support the operation of the dental practices and any other use required by law.

Treatment, Payment, Office Operation:

- We will use and disclose your PHI to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party.
- Your PHI will be used to obtain preauthorization or payment for your dental services.
- Ways we may use or disclose your PHI include, but not limited to, scheduling appointments, discussing your treatment and dental account, making financial arrangements and to communicate reminders about your appointments in person or by mail, e-mail or phone. We will make every effort to be discrete. However, conversations could be overheard by others. If at any time you would desire more privacy let us know.

Other Used and Disclosures: As required by law, your PHI could be disclosed. Other uses and disclosures of your PHI will be made only with your consent. For example, we will not use your information for marketing purposes without your written consent.

Patient Rights:

- You have the right to inspect and copy your protected health information.
- You have the right to request a written restriction of your protected health information, but there is no requirement to honor this request.
- You have the right to request a receipt of confidential communications from us by alternative means.
- You have the right to obtain a paper copy of this notice.
- You have the right to request that we amend your protected health information.
- You have the right to receive an accounting of certain disclosures which have been made.
- All requests must be in writing. We may change for your copies in an amount allowed by law.

Complaints: If you believe your rights have been violated, we urge you to notify our HIPAA Compliance Officer immediately at (206)244-7800 . You can also notify the US Department of Health and Human Services. We will not retaliate against you for filing a complaint.
We thank you for being a patient of Dona M. Seely, DDS, MSD, PS. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information

Diplomate of the American Board of Orthodontics
1248 112th Ave NE • Bellevue, WA 98004 • (425)453-7424 • Fax (425) 646-0799

Notice of Privacy Practices
Acknowledgment and Consent Form
For the office of
Dona Seely, DDS, MSD, PS

Dr. Dona Seely and her staff maintain health and dental records for service we provide you. Our *Notice of Privacy Practices* describes in detail how your health information may be used and disclosed and how you can access your information. A printed copy of our *Notice of Privacy Practices* is available upon request. You may request to see a copy or amend your permanent record by contacting our office.

By my signature below, I acknowledge informed consent and understand the *Notice of Privacy Practices.*

Print Name:_____Signature:_____

Date:_____

Signature required by parent, legal guardian, or personal representative if signed on behalf of the patient.

Print Name:_____Signature:_____

Relationship:_____ Date:_____

(Notation, if any, by staff):

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