DR. SCOTT RUNNELS ORTHODONTICS

HIPAA COMPLIANCE AND GENERAL CONSENT FORM

HIPAA PRIVACY RIGHTS

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the *Health Insurance Portability and Accounting Act of 1996 (HIPPA).* I understand that by signing this consent, I authorize Dr. Scott Runnels, Orthodontics ("you") to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g., my insurance company); and
- The day-to-day healthcare operations and marketing of your practice

I have also been informed of, and given the right to review and secure a copy of, your *Notice of Privacy Practices*, which contains a more complete description of these uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, health care operations, and marketing, but that you are not required to agree to these requested restrictions. However; if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR TREATMENT

I hereby authorize Dr. Scott Runnels, Orthodontics and its employees, staff, and agents to take x-rays, study models, photographs and/or any other diagnostic aids deemed necessary by the treating orthodontist to make a thorough diagnosis of me or my dependent's dental needs.

Upon such diagnosis, I authorize Dr. Scott Runnels, Orthodontics to perform all recommended treatment agreed upon by me, and to give such assistance as required to provide proper care. **I understand that I may ask for a full explanation of any possible complications.**

Additionally, I authorize Dr. Scott Runnels, Orthodontics to contact me at all telephone numbers and addresses provided by me and updated by me, or available through public records.

I, ______________________________, am the parent with legal authority (not terminated by any court) or legal guardian with the legal authority to consent to the above for _________________________________, DOB______________.

_______________________________________ ___________

Signature of Patient, Parent or Legal Guardian Date