Bedford Orthodontics

Orthodontics for children and adults

Confidentiality Policy for Patients

Dr. Hesby and his staff are committed to providing you with the highest quality care and to forming a relationship with you that is built on trust. That means respecting your privacy and the confidentiality of your personal health information. We protect your privacy and confidentiality rights by creating and putting into practice policies and procedures that allow access to your personal health information only for purposes related to your treatment. We will request your authorization at your first or next visit by asking you to sign our "Consent for Use and Disclosure of Health Information Form".

As we provide your care, we are required to maintain a complete copy of the medical history you provided to us, your treatment plan, and all treatment given, including all x-rays and photographs. Whether this information is stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality. Of course, Dr. Hesby and other healthcare professionals who are involved in your care need to access this information in order to provide appropriate treatment for you. We do not allow others outside our practice to access your medical information unless we have the appropriate authorization to do so.

You, or anyone to whom you give permission, have the right to read or receive a copy of your personal health information. Your treatment record is the physical property of this practice. However, in the event that a medical/dental care provider will be treating one of our patients, we will share radiographs and other necessary or helpful information with that person unless specifically instructed not to by you or your legal agent.

Our staff members are trained in the appropriate use of medical information and know that it is available to them only to continue to provide care to you or for other limited but legitimate reasons. A violation of confidentiality or the failure of an employee to protect your information from accidental or unauthorized access will not be tolerated. This may include the employee being fired from his or her job.

Please note, however, that the law requires some information to be disclosed in certain circumstances. This includes mandatory reports or abuse of children or elderly or disabled persons.

Because of the open-bay operatory we use for patient care, and the relatively small space that we work in, there may be times that you may feel you need a more private venue. Please feel free to ask anyone on our staff to speak to you in another room if a sensitive or personal subject need be discussed.

If you have questions about the privacy of your healthcare records, please speak with Dr. Hesby or a member of the office staff. We will be happy to help you.

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

RICHARD M. HESBY, D.D.S., M.S.

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Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of
(Please Print Parent/Guardian Name)

Privacy Practices.

_____
Signature

_____
Date

_____
Patient Name

****

For Office Use Only

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)

_____

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