HAMILTON ORTHODONTICS

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 importantto us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of yourhealth 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 reserve the right to make the changes in our privacy practices and the new termsof 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 a new notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment to be reimbursed to you the insured, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or otherhealthcare provider providing treatment to you.

PAYMENT: We do not accept insurance assignments and will only disclose your information so you may be reimbursed for any services we provide. By signing, youhave given us permission to fax, email, or mail any info for your reimbursement.

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 qualificationsof healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialingactivities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, reimbursement of payment to the insured, or healthcare operations, you may give us written authorization to use your 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 of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your information for any reason except those described in thisnotice.

TO YOUR FAMILY AND FRIENDS: We may disclose your information to a family member, friend or other person to the extent necessary to help with your healthcare or reimbursement of payment to the insured, 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 other 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 disclosing only health information that is directly relevantto the person's involvement in your healthcare. We will also use 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 you health information formarketing communications without your written authorization.

We may also use or disclose your protected health information in the following situations without your authorization: Abuse or neglect, national security, and asrequired by law.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards,emails, or letters).

PATIENT FLOW IN OFFICE: Our office uses a computer method of patient flow through our office. Upon arrival, the patient will check in with the front desk or on a computer at our front desk. They will then be called back, by name, to the clinical area by theorthodontic assistant for treatment. We also work in an open bay setting and therefore have conversations about treatment in an open environment. If you prefer private treatment, please let us know.

RECORD DUPLICATION: Many times dental professionals need to share records (x- rays, study models, photographs) for diagnostic purposes. (i.e. In the event of your transfer from our office to another orthodontist.) I understand that by signing to thereceipt of this document, I allow the records to be duplicated and shared with other dental/health professionals. Your signature also allows our office to request diagnostic records from other offices for our diagnostic purposes.

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other that photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. Youmay obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $.25 for each page, and $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an

alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your heath information for a fee. Contact us using the informationlisted at the end of this notice for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in whichwe or our business associates disclosed your health information for purposes, other than treatment, payment to be reimbursed to the insured, healthcare operations and certain other activities, for the last 6 years, but not before April 14th, 2003. If you request this accounting more that once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions onour 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 inan emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments to the insured will be handled under the alternative means or location yourequest.

AMENDMENT: You have the right to request that we amend you health information. (Your request must be in writing, and it must explain why the information should beamended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this notice on our web site or by electronic main(e-mail), you are entitled to receive this notice in written form.

QUESTIONS OR 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 or in response you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, 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 any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT OFFICER: Jayme Blalock

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