Saratoga Periodontics

(518) 587-7512

450 Maple Avenue, Saratoga Springs, NY 12866

Notice of Privacy Practices

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 Accountability Act of 1996. (HIPAA). I have been informed that I may review the Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I give Saratoga Periodontics, P.L.L.C. my consent to use or disclose my protected health information as described below:

- 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);
- The day-to-day healthcare operations of your practice, including direct mailings and phone confirmations and/or messages.

I understand that I am responsible for all cost of dental treatment and I agree to pay any legal interest on the balance due, together with any collection costs and attorney fees incurred in the attempt of collection of this account.

I understand that Saratoga Periodontics, P.L.L.C. has the right to change their privacy practices and that I may obtain any revised notices at Saratoga Periodontics, P .L.L.C.

I understand that I have the right to request a restriction of how my protected health information is used and disclosed to carry out treatment, payment, and health care operations. However, I also understand that Saratoga Periodontics, P.L.L.C. is not required to agree to this request. If Saratoga Periodontics, P.L.L.C. agrees to my requested restrictions they must follow the restrictions.

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

Signature:_____ Date: _____

Patient, Parent or Legal Guardian

Witnessed by:_____ Date: _____