Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Use of electronic communication (fax, voicemail, texting) to transmit treatment, appointment changes, any related information and/or other results.

I hereby authorize all providers, including Physicians and Physician Assistants to furnish information to medical insurance carriers concerning myself or my dependents illnesses and treatments and hereby assign to the doctor all payments for medical/dental services rendered. I understand that I am responsible for providing any and all insurance information at the time of services, and that I will be responsible for any amount not covered by insurance.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the office at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient (Parent) (Self) (Guardian)

Signature _____ Date_____

Photo Image Release

I, the undersigned, authorize Marlo Miller Orthodontics and her employees to take photos, videos, or digital records of me to use in all medias.

I further consent my name may be revealed therein or by descriptive text or commentary.

I release all rights to exhibit this work in prints and electronic form publicly.

Patient Name _____

Relationship to Patient (Parent) (Self) (Guardian)

Signature _____ Date_____