HIPAA

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF:

Vanguard Orthodontics

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact

Vanguard Orthodontics

Of our office at

8191 Maple Lawn Blvd
Fulton, MD 20759

tc@vanguardsmiles.com
410 381 1077

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order.

Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner.

This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to:

Vanguard Orthodontics

Of our office at

8191 Maple Lawn Blvd
Fulton, MD 20759

tc@vanguardsmiles.com
410 381 1077

in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you

are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to:

Vanguard Orthodontics

Of our office at

8191 Maple Lawn Blvd
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It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper,

electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

We may not (and are not required to) agree to your restrictions with one exception: If you pay in full (out of pocket) for a service you receive from us, and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact:

Vanguard Orthodontics

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to:

Vanguard Orthodontics

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail or to contact you by text or your cell phone number regarding appointments, treatment, insurance, and your account. You can withdraw your consent from our policy at any time and request your confidential communication preferences, by completing and submitting the Requests For Restricting Uses and Disclosures and Confidential Communications to:

Vanguard Orthodontics

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

8191 Maple Lawn Blvd
Fulton, MD 20759

tc@vanguardsmiles.com
410 381 1077

You will not be penalized for filing a complaint.

Signature _____

Welcome to Vanguard Orthodontics. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.

CHILD/ADOLESCENT PATIENT INFORMATION

Date_____

Patient's name_____Male/Female_____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home phone_____ Work phone _____

Birthdate_____

How did you hear about our practice? _____

PARENT/LEGAL GUARDIAN INFORMATION

FATHER

Name_____
Last First Middle

Address (if different from patient) _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home phone_____ Work phone _____

Cell Phone #_____ Carrier (e.g. Verizon/AT&T)_____

Birthdate_____ Email Address_____ Marital Status: Single__ Married__

Employer_____ Occupation_____ No. years employed _____

MOTHER

Name_____
Last First Middle

Address (if different from patient) _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home phone_____ Work phone _____

Cell Phone #_____ Carrier (e.g. Verizon/AT&T)_____

Birthdate_____ Email Address_____ Marital Status: Single__ Married__

Employer_____ Occupation_____ No. years employed _____

Vanguard ORTHODONTICS

DENTAL INSURANCE INFORMATION

Insurance Company_____

Group No._____ Policy No._____

Employer_____ Work Phone No._____

Policy Holder's Name_____Relation_____

Policy Holder's Social Security #_____Policy Holder's DOB_____

Insurance Company Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insurance Company_____

Group No._____ Policy No._____

Employer_____ Work Phone No._____

Policy Holder's Name_____Relation_____

Policy Holder's Social Security #_____Policy Holder's DOB_____

Insurance Company Phone No._____

EMERGENCY INFORMATION

Emergency contact name _____

Relation _____

Address _____

Phone _____

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MEDICAL HISTORY

Physician _____ Date of Last Visit_____

Address _____ Phone _____

Please check Yes or No (If Yes, please fill in details – additional space provided below)

- Is the patient currently being treated by a physician? Yes❑ No❑
  Reason:
- Is the patient currently taking any medications including over-the-counter? Yes❑ No❑
  (Please List)
- Is the patient allergic to any medications? Yes❑ No❑
- Does the patient have a history of a major illness? Yes❑ No❑
- Has the patient had any operations? Yes❑ No❑
- Has the patient ever been involved in a serious accident? Yes❑ No❑

Check any of the medical conditions below that the patient has or has had previously:

❑Abnormal Bleeding/Hemophilia	❑Diabetes	❑Hepatitis/Liver problems	❑Pneumonia
❑Anemia	❑Dizziness	❑Herpes	❑Prolonged Bleeding
❑Arthritis	❑Epilepsy	❑High Blood Pressure	❑Radiation/Chemotherapy
❑Asthma or Hay Fever	❑Gastrointestinal Disorders	❑HIV/Aids	❑Rheumatic Fever
❑Bone Disorders	❑Heart Problems	❑Kidney Problems	❑Tuberculosis
❑Congenital Heart Defect	❑Heart Murmur	❑Nervous Disorders	❑Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

DENTAL HISTORY

Vanguard ORTHODONTICS

General Dentist_____ Date of last visit_____

What concerns you or your child most about your child's teeth?

- Is the patient presently in any dental pain? Yes❑ No❑
- Have the patient's wisdom teeth been removed? Yes❑ No❑
- Has the patient ever lost or chipped any teeth? Yes❑ No❑
- Have there been any injuries to face, mouth, or teeth? Yes❑ No❑
- Do gums bleed when brushing? Yes❑ No❑
- Is the patient a mouth breather? Yes❑ No❑
- Has the patient previously visited an orthodontist? If so, how recently? Yes❑ No❑
- Has the patient ever experienced any jaw joint pain/discomfort (TMJ/TMD)? Yes❑ No❑
- Does the patient experience jaw clicking or popping? Yes❑ No❑
- Does the patient grind their teeth (this generally occurs while sleeping)? Yes❑ No❑
- Have the patient's tonsils or adenoids been removed? Yes❑ No❑
- Are there speech problems? Yes❑ No❑
- Does the patient have (or has the patient previously had) any of the following habits: lip sucking/biting, nail biting, chewing/eating problem? Yes❑ No❑

BENEFITS

I understand that the information that I have provided is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in the patient's medical status.

I hereby authorize the release of any information pertaining to my child's orthodontic treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____