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. We are required to provide you with a copy of this document. By signing this form you acknowledge receipt of this notice. You may refuse to sign this acknowledgement if you wish.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health 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 must follow the privacy practices that are described in this notice while it is in effect. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law.

We reserve the right to make the changes in our privacy practices and the new terms of 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 the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosure of Health information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: **Treatment:** We may use or disclose your health information to a physician, dentist or other healthcare provider providing treatment to you. **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

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 qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

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

To Your Family & Friends

We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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 another 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 relevant to 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.

In the event that AvA Orthodontics is required to provide information regarding your treatment to other health care providers as deemed appropriate, once the information is released, AvA Orthodontics, doctors and staff have no responsibility for any further released by the individual or entity receiving your information.

Required by Law

We may use or disclose your health information when we are required by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Your Privacy Rights as our Patient

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 than unencrypted emails or 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. You may 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 $5.00 for each page, $15.00 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 health information for a fee. Contact us using the information listed 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 which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before March 20, 2014. If you request this accounting more than 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 on our 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 in an 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 will be handled under the alternative means or location you request.

Amendment

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

Electronic Notice

If you receive this notice on our website or via an e-mail, you are entitled to receive this notice in written form, provided upon request.

Question and Complaints

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 to a request 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.

How to Contact Us

Office Manager of each offices

Method of Communication

It may become useful during the course of your treatment to communicate via email, text message or via other electronic methods. All of these methods of communication are non-encrypted, therefore they are not considered fully secure, and do not meet the security requirements set forth by HIPAA. There is always a risk that a third person can have access to the exchanged data. These third parties may include, but not limited to:

- A member of your household or other place who may have access to your phone, computer, etc.
- Your employer or colleagues if you use your work email to communicate with AvA Orthodontics.
- Your Internet provider such as server administrators and internet traffic monitoring crew.

I, as a patient or a parent of a patient allow AvA Orthodontics to use unsecured email and mobile phone text messaging to transmit my following protected health information:

- Scheduling/Reminder of appointments
- Billing and payments and other information regarding my financial agreement.
- Filling and following up with insurance claims.
- Therapeutic or clinical nature relevant to treatment with other health care providers.

I understand and agreed with the following:

- I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time in writing.
- Any information may or may not disclose my individually identifiable information, such as names, date of birth, phone/fax number, email address, demographic data, radiographic images, treatment related photos, treatment findings and recommended treatment plan.
- I have been informed of the risks, including but not limited to my confidentiality in treatment, via transmitting my protected health information by unsecured means.
- This authorization will automatically terminate one year after the end of your treatment.

Photos & Social Medias

I, hereby consent to AvA Orthodontics to the making of diagnostic records, including x-rays, and photographs before, during and after my treatment. I hereby give my permission for the use of these orthodontic records for the purpose of professional consultations, research, education, or publication in professional journals.

AvA Orthodontics also request your permission to use videos and photos taken of you or your child to showcase before and after smiles and fun memories during your treatment. These photos may appear in one or all of the platforms below: Office bulletin board, office walls, before & after album, educational presentation to dental professional and general public, practice website, and social media such as Facebook, Twitter, Instagram, YouTube, etc.

I, as a patient or a parent of a patient, authorize the use and disclosure of my name, photographic or video images for the purpose of testimonial or other marketing purposes by AvA Orthodontics. I understand that information disclosed pursuant to this authorization may be subject to disclosure and may no longer be protected by HIPAA privacy regulations. I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive.

Acknowledgement

I acknowledge that I have received a copy of this office's notice of Privacy Practices and have read the contents. I understand that I am giving my consent to use and disclose my health care information to carry out treatment, education, payment activities and health care operations.