Rapid City Smiles Implant and Family Dentistry LLC
CONSENT AND ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We believe you have the right to know what we do with the health information we gather about you as a patient of Family Smiles Dental. We use and disclose health information about you for treatment, payment and healthcare operations. We also want to assure you that we are properly safeguarding this important information. Because we value our relationship with our patients, we have prepared the following summary of our privacy policy, which is based on the federal law governing patient privacy and on our own high standards of patient confidentiality.

We need accurate, current health information about you so that we can determine your dental needs and recommend treatment to meet your specific needs. We collect personal information that you provide to us on a registration forms and interviews. In addition, we may receive information from other health care providers authorized by you.

We will share your health information only with authorized employees, and other authorized healthcare professionals whose service may be required to assure the highest level of service to you. We may use or disclose your health information to provide you with appointment reminders such as voice mail, messages, postcards, or letters. We will not disclose any health information about you, except as authorized by you. By law reasonable belief that you are a victim of abuse, neglect, or domestic violence, as described in this privacy statement or as otherwise communicated to you.

You have the right to see and request (in writing) that we amend your health information. We may deny your request under certain circumstances. We will protect all information collected about you, and we will restrict access to your records by maintaining physical, electronic and procedural safeguards.

If you have any questions or concerns about our privacy practices, please contact us. We support your right to the privacy of your health information.

<u>All statements must be paid in full within 90 days of service. Failure to do so, will result in your account being turned over to out collection agency with a $200.00 added fee.</u>

Contact Officer Dr. Dan Graves, DMD
Telephone: 605-716-7800
Address: 1801 Mt. Rushmore Road Rapid City, SD 57701

I, _________________________________, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practice. I understand that, by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Print Name: ____

Signature:____ Date_____________________

*You may refuse to sign this acknowledgement.
Is there someone you'd like to authorize to have access to your records?

Name: ______________________________________ Contact Phone #_______________________