

Riverbend Family Dentistry
10088 W Indiantown Rd
Jupiter, FL 33478

Phone: 561-701-9700
info@riverbendfamilydentistry.com



PRIVACY POLICY (HIPAA POLICY)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice you may obtain a revised copy by visiting our website at www.riverbendfamilydentistry.com

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, insurance billing, or healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands that:

- Protected health information may be disclosed or used for treatment payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of the information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA Consent Form, therefore payment in full is required on the same day of services.

I, as the patient or parent/legal guardian, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. 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, insurance billing, and healthcare operations. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This legislation provides data privacy and security provisions for safe guarding your medical information.

You may also file a complaint if you feel your rights have been violated. You may contact our Privacy Officer, Shannon Lackner, 10088 W Indiantown Rd., Jupiter, FL 33478, 561-701-9700, shannon@riverbendfamilydentistry.com or US Department of Health and Human Services office for Civil Rights, 200 Independence Ave S.W., Washington, D.C. 20201, 877.696.6775 or www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate for filing a complaint.

I have been informed of this policy and have been offered a written copy.

Patient's Name: _____

Signature: _____

Date: _____

Effective date: September 23, 2013
Revised date: October 7, 2020