BARRON
Family Dental

Your Rights:

You have the right to:

- Request that we restrict how we use or disclose your health information. We may not be able to comply with all requests.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information (fees may apply). *
- Request additions or corrections to your health information. *
- Receive an accounting of how your health information was disclosed (excludes disclosures for treatment, payment, healthcare operations, and some required disclosures, as well as disclosures that you authorize). *
- Obtain a paper copy of this notice even if you receive it electronically.

Requests followed by an asterisk (*) must be in writing.

Financial Privacy Policy

We do not give your financial information to any person or persons not affiliated with Barron Family Dental. It is important to us that you understand what financial information we gather and how we use it to administer your benefits and serve you better.

- Financial information- In order to provide your dental services, we may gather financial information about you from you, your employer, your plan sponsor, or your dentist with respect to claims, co-payments, and premium payments.
- Security- In compliance with state and federal standards, electronic, procedural and physical safeguards are in place to limit the collection and use of non-public information to the minimum necessary to provide you with quality products and services. Access t this information is limited to a “need to know” basis for our employees to perform their jobs. This applies to you where you are a former or current member.

Confirmation of Policy Review

By signing this form you acknowledge that you have seen this HIPPA Privacy Policy and that you have read all of the HIPPA Privacy Policy and that you understand the HIPPA Privacy Policy.

Adult patient, Parents and Legal Guardians reviewing this HIPPA Privacy Policy please print your name, sign and date below:

Print: Patient/Parent/Legal Guardian_____Date: _____.

Signature: Patient/Parent/Legal Guardian_____Date: _____.