



# LEGENDS DENTAL

— Ryan Ward, DDS —

FAMILY | IMPLANTS | COSMETICS

Dear Patient:

As a health care provider, our office is subject to State and Federal laws regarding the confidentiality of your health information. In keeping with these laws, we want you to understand our procedures and your rights as our valuable patient. We are taking the *new* Federal **HIPAA-Health Insurance Portability and Accountability Act** laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay your treatment because you are afraid your health information might be unnecessarily made available to others outside of our office.

We will use and communicate your health information **only** for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

Yes, this creates more paperwork, but when you complete and sign these forms, we become partners in protecting the privacy of your health information. **If you have any questions, one of our team members would be happy to assist you.**

**LEGENDS DENTAL  
DR RYAN WARD, D.D.S. P.A.  
NOTICE OF PRIVACY PRACTICES**

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations, if necessary.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read the "Notice of Privacy Practices" carefully and completely before signing this Consent. ***Please note: You may refuse to sign this consent. However, we cannot communicate with your insurance company without consent from you. You will then be required to file all insurance claims directly with your insurance company and pay fees in full at each visit.***

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and to review the Notice of Privacy Practices. ***I understand that, by signing this form, I am giving my consent to you for the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations for myself (and applicable members of my family under the age of 18), when necessary. I have been given the opportunity to keep a copy of the "Notice of Privacy Practices" for my records if I desire.***

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Patient (if child, parent/legal guardian)

Names of all patients in family under the age of 18:

1.
2.
3.
4.
5.

**Information Sharing:** Please list any individuals we can share your personal information with other than healthcare providers:

1.	Relationship:
2.	Relationship:
3.	Relationship:

**Our Office Use Only**

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

\_\_\_ Individual refused to sign

\_\_\_ Communications barrier prohibited obtaining the acknowledgement

\_\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_\_ Other (Please Specify):