NOTICE OF PRIVACY PRACTICES

In the office of Dr. Trason Shoquist DMD, and we as always are doing our utmost to protect sensitive medical, financial and personal information of our patients. However, in communicating with our patients we do find the need to leave telephone messages or to send correspondence. Typically messages would include, but not limit us to informing the patient that additional treatment is needed, inform patients of need for additional appointments, remind patients of upcoming appointments, and to leave messages asking the patient to return a call. We would of course never leave personal account information or confidential medical information other than the need for premedication.

The only time we would pass on any of your confidential information to another office or business, including dental labs, would be to refer or complete your treatment, file your insurance claim or to proceed with collection of your account. If we find the need to pass on information for any other reason, we would have you sign a specific form allowing us to do so.

(WE DO HAVE THE RIGHT TO PROCEED WITH THE COLLECTION OF YOUR ACCOUNT.)

(REFERRING TO PATIENT, MEANING PATIENT OR AUTHORIZED REPRESENTATIVE.)

I HAVE READ THE ABOVE INFORMATION AND **AGREE** WITH THESE PRACTICES:

_____

Signature of patient or patient's authorized representative Date signed

I HAVE READ THE ABOVE INFORMATION AND **DISAGREE** WITH THESE PRACTICES:

_____

Signature of patient or patient's authorized representative Date signed

LIST BELOW THE PRACTICES YOU DISAGREE WITH: _____

_____

_____

_____

ADDITIONAL DATES INITIAL: (VALID FOR TWO YEARS FROM LAST DATE SIGNED)

_____

_____

_____

DEPENDANTS EIGHTEEN YEARS AND OLDER SIGN FORM ON BACK

CONSIDERING THAT I AM EIGHTEEN YEARS OF AGE OR OLDER, AND STILL DEPENDANT ON MY PARENT OR GUARDIAN, REALIZE AS AN ADULT MY PERMISSION IS NECESSARY FOR SPOKANE DENTAL TO DISCLOSE MY DENTAL AND FINANCIAL INFORMATION TO MY FAMILY MEMBERS TO FACILITATE MY TREATMENT AND PAYMENT, I GIVE MY PERMISSION FOR THIS UNTIL SUCH TIME I REQUEST NOT TO DO SO.

SIGNATURE_____DATE_____

I, _____ REALIZE THAT MY PERMISSION IS NECESSARY FOR SPOKANE DENTAL TO DISCLOSE MY DENTAL AND FINANCIAL INFORMATION TO MY FAMILY MEMBERS TO FACILITATE MY TREATMENT AND/OR PAYMENT. I GIVE MY PERMISSION TO RELEASE THIS INFORMATION TO THE FOLLOWING PERSON(S)_____

_____UNTIL SUCH TIME I REQUEST NOT TO DO SO.