Nashville Center for Aesthetic Dentistry

Our Privacy Pledge

We have always been concerned with protecting your privacy, and will continue to do so. The law requires us to provide you with this disclosure outlining how we handle your personal health information. Please review the following and acknowledge receipt of our policies with your signature below. If you have any questions about your privacy, please ask any of our team members for more information.

There are several circumstances in which we may need to use or disclose your health information.

- We may disclose your personal and health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your dental condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control purposes or in order to provide optimal comfort and care.
- We may need to access your name, address, phone numbers, and clinical information in order to contact you with appointment reminders, information about treatment, or updated information that may be of interest to you.
- We may need to disclose information about your completed treatment as requested by your insurance company's representatives in order to facilitate settlement of claims for your reimbursement.

We reserve the right to change our privacy practices as described above. If we make any changes to our privacy policy, you will be notified in writing by mail or when you come to our office. If you have specific questions about how we handle your health information, or how our policy relates to a particular situation, please feel free to ask us at any time.

Your Right to Limit Uses or Disclosures

You have the right to request that we not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. If we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent at any time; however, your revocation must be in writing. We will not be able to honor your request if your health information has been released prior to receiving your written request.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____	_____
Patient Name (print)	Date
_____	_____
Signature	Authorized Provider Representative