

**Privacy Policy**

***Patient Consent Form:*** For Collection, Use and Disclosure of Personal Information Privacy of your personal information is an integral and of utmost importance in our dental hygiene practice. We understand the importance of protecting your personal information. We pledge to collecting, using and disclosing your information responsibly. Our practice and privacy protocols comply with the rules governed by the PIPEDA, our governing body the CDHO in handling all information obtained. Storage and retention of your personal information complies with existing legislation.

Our office will collect information about you for the following purposes:

1. To provide safe and efficient patient care.
2. To assess your health needs.
3. To allow us to contact you.
4. To advice and recommend treatment options.
5. To cultivate and retain efficient communication.
6. To offer and provide treatment, care and services related to our field of expertise.
7. To communicate with other health care providers, including specialists and general dentists for possible referral as deemed necessary.
8. To allow us to communicate with you to book and confirm appointments.
9. To grant us the accessibility to impart dental health care information.
10. To allow us to efficiently follow up for treatment, care and billing services.
11. To complete and submit dental claims and payment.
12. To comply with legal and regulatory requirements, including the delivery of patients’ charts and records to the CDHO when required in accordance to the provisions of the Regulated Health Professions Act.
13. To process credit card payments.
14. To collect unpaid accounts.
15. To assist the office to comply with all regulatory requirements.

By signing the consent section, you have acknowledged that you have given your informed consent to the collection, use, disclosure of your personal information for the purposes that are listed above.

You may withdraw your consent and we will explain the implication of the decision.

**Patient Consent**

I have reviewed the above information on how your practice will use my personal information and the manner that your office is undertaking to protect my privacy.

***Patient’s Name:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Signature:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Date:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_