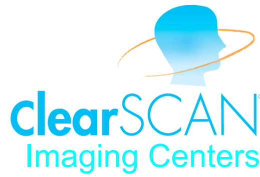

“Defining A *New* Standard Of Care”

PHOENIX
1515 E. Missouri Ave
Phoenix, AZ, 85014
Phone: (602) 808-9700
Fax: (602) 955-0680

CHANDLER
800 W. Chandler Blvd, Suite 2
Chandler, AZ, 85225
Phone: (480) 814-7117
Fax: (480) 814-7214

Date: ____

Patient’s Name: ____
Last First Middle

Address: ____

____
City State Zip

Date of Birth: ____________________ **Gender:** ____________________

Phone #: ____________________ **E-Mail:** ____________________

Name of referring dental Doctor: ______________________________

I authorize the Clear-Scan Imaging Centers to made procedures deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility. I give consent to release any information including and regarding my exams at CSIC to my referring physician or other health care providers involved in my treatment. I acknowledge that I have seen and understand CSIC’s Privacy Notice. I also agree to make full payment of any procedure at the time of the appointment.

Signature of Patient, legal guardian, or authorized agent of the patient:

____

CLEAR-SCAN IMAGING CENTERS - **PRIVACY NOTICE**
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. PLEASE REVIEW IT CAREFULLY!

Please remove gum, jewelry, removable partials, retainers, or any other metal objects from head and neck only.

www.clear-SCAN.com

"Defining A *New* Standard Of Care"

INSURANCE:
I understand that Clear-Scan does **not** bill health or dental insurance and does **not** accept insurance payments. I understand that the receipt for Clear-Scan services will include CPT codes that will enable me to submit claims to my insurance carrier. However, I understand that the charges for Clear-Scan services may **not** be covered or reimbursed by health or dental insurance.
Initials: __________
PAYMENT FOR SERVICE:
I understand that I must pay for all charges at the time of service. If this account is not paid and is sent for collection, I agree to pay reasonable attorney fees and all collection expenses.
Initials: __________
VERIFICATION OF NON-PREGNANCY FOR FEMALE CLIENTS
I understand that dental imaging may be hazardous to an unborn child. I certify that to the best of my knowledge, I am not pregnant (or if I am consenting on behalf of the Client, that the Client is not pregnant). I agree that if I (Client) am or may be pregnant, I will notify a Clear-Scan employee before receiving any dental imaging services.
***Initials:* ___________**

1. Purpose: Clear-Scan Imaging Centers follows the privacy practices described in this Notice. For purposes of this Notice, Clear-Scan Imaging Centers is defined as all professional staff, and employees (hereinafter CSIC). CSIC maintains your health information in records that will be maintained in a confidential manner, as required by law. However, CSIC must use and disclose your health information to the extent necessary to provide you with quality health care. To do this, CSIC must share your health information as necessary for treatment, payment and health care operations.
2. How Will CSIC Use My Health Information? Your health information may be used for the following purposes:
• Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment.
• Payment: We may use and disclose your health information to obtain payment for services we provide to you.
• Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
• Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
• To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
• Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays or other similar forms of health information.
• Marketing Health Related Services: We may use or disclose your health information when we are required to do so by law.• Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of

abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others.

• National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

• Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

3. Your Authorization Is Required for Other Disclosures. With the exception as described above in this Notice, we will not use or disclose your health information unless you authorize (permit) CSIC in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

4. You Have Rights Regarding Your Health Information. You have the following rights regarding your health information, provided that you make a written request to invoke the right on the form provided by CSIC.

• Right to request restriction. You may request limitations on your health information we use or disclose for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular surgery), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. You may request a restriction on the form provided by CSIC. The request should be filed by using the contact information at the end of this Notice.

• Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted. You may request confidential handling of information on the form provided by CSIC. The request should be filed using the contact information at the end of this Notice.

• Right to inspect and copy. You have the right to inspect and copy your health information regarding decisions about your care including mental health notes, however, mental health records may be withheld if the health care provider determines, in their best judgment, that the information requested is detrimental to the physical and mental health of the patient, or likely to cause the patient to harm himself or another person. Upon written request and reasonable notice, you may request access and/or copies by using the contact information at the end of this Notice. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by CSIC. CSIC will comply with the outcome of the review.

• Right to request amendment. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by CSIC, which requires certain specific information. The request should be filed using the contact information at the end of this Notice. CSIC is not required to accept the amendment.

• Right to accounting of disclosures. You may request a list of the disclosures of your health information that have been made to persons or entities other than for health care treatment, payment, or operations in the past six (6) years, but not prior to April 14, 2003. After the first request in a 12 month period, there may be a charge. You may request an accounting of disclosures on the form provided by CSIC. The request should be filed using the contact information at the end of this Notice.

• Right to a copy of this Notice. You may request a paper copy of this Notice at any time.

5. Requirements Regarding This Notice. OMFIC is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. OMFIC may change this Notice and these changes will be effective for health information we have about you as well as any information we receive in the future. Each time you register at OMFIC for health care services as an inpatient or outpatient, you may receive a copy of the Notice in effect at that time.

6. Complaints. If you believe your privacy rights have been violated, you may file a complaint with OMFIC or with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or retaliated against in any way for making a complaint to OMFIC or the Department of Health and Human Services.