CELLPHONE / CAMERA / VIDEO POLICY

It is the policy of Children's Dental Specialists of Lake County that photography and video by any means, including cellphones, is PROHIBITED in our clinic area. The only exception is photography by our employees for treatment purposes. Our concern is patient privacy for all patients and federal law (HIPPA). We respect the privacy of all our patients and require all patients to respect the privacy of every other patient.

If this policy is violated in any way, Children's Dental Specialists of Lake County, reserves the right to terminate treatment and dismiss the family from the practice.

Therefore we require that all individuals who enter the clinic area have all electronic devices silenced and put away for the duration of the time in the clinic area.

If you would like a special photo of your child during their appointment, please ask us, we would be more than happy to assist you.

______________________________________ ____________________

Parent/Guardian (Signature) Date

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Patient's Name (Print)

PRIVACY CONSENT

This form is required by the new patient privacy regulations recently issued by the United States Department of Health and Human Services. Prior to commencing or continuing your treatment at Children's Dental Specialists of Lake County Drs. Richards and Miller, Inc., you must review, sign, and date this form.

Your protected health information (i.e. individually identifiable information such as your names, dates, phone/fax number, email addresses and demographic data) may be used in connection with your treatment, payment of your account, or health care operations (i.e. performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However; such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

______________________________________ ____________________

Parent/Guardian (Signature) Date

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Patient's Name (Print)