Hawaiian Smiles
ORTHODONTICS

NEW PATIENT FORM (CHILD)

Dr. Satya Nayak | Phone (808) 247-6039 | Fax (808) 247-3643
Kaneohe: 45-939 Kamehameha Hwy, Suite 103 | Kona: 76-6225 Kuakini Hwy, D-101
Waimea: 65-1230 Hawai'i Belt Rd, A21 | Hilo: 280 Ponahawai St, #101

** Mandatory field required ☐ = checkbox*

PATIENT INFORMATION

***Patient's First & Last Name:** ***Sex: ☐ Male ☐ Female ☐ Non-binary**

***Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____**

***Address:** ***City:** ***State:** ***Zip Code:** ***School:**

***Date of Birth:** ***Cell #:** ***Home #:**

***How did you hear about us / Who referred you to our office?**

***Email Address:** ***Best number to receive text messages:**

***Communication Preference — please select one:**
☐ I consent to receive appointment reminders, statements, and updates via text or email. I understand standard carrier rates may apply for text messages.
☐ I do **not** wish to receive electronic communications. I understand I may miss appointment reminders and important documents.

RESPONSIBLE PARTY INFORMATION *(Person(s) financially responsible for this account)*

RP#1 — Primary Responsible Party *(will receive monthly statements by email unless otherwise requested)*

***First Name:** ***Last Name:** ***Date of Birth:**

***Resident Address:** ***State:** ***Zip Code:**

***Mailing Address (if different):** ***State:** ***Zip Code:**

***How long at this address?** ***Do you rent or own your home? ☐ Rent ☐ Own**

If less than one year — previous address:

***Relationship to Patient:** ***Marital Status:** ***Email:**

***Employer:** ***Occupation / Military Rank:** ***Years Employed:**

RP#2 — Secondary Responsible Party *(optional)*

First Name: **Last Name:** **Date of Birth:**

Mailing Address: | **State:** | **Zip Code:**

Relationship to Patient: | **Relationship to RP#1:** | **Email:**

Employer: | **Occupation / Military Rank:** | **Phone Number:**

IN CASE OF AN EMERGENCY — Nearest relative not living with you:

***Name:** | ***Relationship to Patient:**

***Cell Phone:** | **Home Phone:**

SEPARATED / DIVORCED PARENTS — CUSTODY & AUTHORIZATION ↓ *Skip this section if parents are together and both listed as Responsible Party above*

This section ensures that we have accurate legal authorization for treatment and communication on behalf of your child. A copy of any relevant court order or custody agreement may be requested.

Is there a custody agreement or court order governing this child's medical and dental care? ☐ Yes ☐ No

If yes: ☐ Sole legal custody — only one parent may consent to treatment

☐ Joint legal custody — both parents share consent authority

☐ Other arrangement — please describe: _____

Which parent / guardian is the primary point of contact for treatment decisions and scheduling?

Name: | **Relationship to Patient:**

Who else is authorized to receive information about this child's treatment? *(Check all that apply)*

☐ Both parents equally ☐ Primary RP only ☐ Both RPs listed on this form ☐ Other: _____

Who is authorized to pick up or drop off this child for appointments? *(Check all that apply)*

☐ Either parent ☐ Primary RP only ☐ Any adult listed on this form ☐ Other: _____

Are there any persons who are NOT authorized to pick up this child or receive information about their care? ☐ Yes ☐ No

If yes, please describe: _____

Note: Hawaiian Smiles Orthodontics reserves the right to request a copy of any court order before proceeding with treatment or releasing information. If custody arrangements change, please notify our office in writing promptly.

DENTAL INSURANCE *(Please bring your Dental Insurance Card to your appointment, or to make things easier, TEXT a photo of your insurance card to* **(808) 247-6039***.)*

If you have MetLife or United Concordia insurance, please use your Social Security Number as the Subscriber Number.

Primary Policy Holder's Name: | **Subscriber # / SSN:** | **Date of Birth:**

Insurance Company: | **Group #:** | **Local #:**

Do you have dual (secondary) dental coverage? ☐ Yes ☐ No

Secondary Policy Holder's Name: | **Subscriber # / SSN:** | **Date of Birth:**

Insurance Company: | **Group #:** | **Local #:**

Insurance Authorization & Signature

By signing below, I authorize Hawaiian Smiles Orthodontics to: (1) verify my credit and obtain necessary financial information; (2) receive and apply any insurance benefits directly to my account for services rendered; and (3) release information required to process insurance claims. This authorization applies to all insurance submissions on my behalf.

***Signature:** | ***Date:**

CHILD MEDICAL / DENTAL HISTORY

Physician's Name: **Phone:**

Dentist's Name: **Phone:**

Date of Last Dental Cleaning: **Preferred Language:**

Why is your child seeking orthodontic treatment? *(Check all that apply)*

☐ To straighten teeth ☐ To improve confidence
☐ To correct the bite ☐ To resolve jaw pain or discomfort
☐ Special occasion coming up
☐ Referral from general dentist — reason for referral not yet fully understood (I would like a thorough explanation of why orthodontic evaluation was recommended)

Has your child seen an orthodontist before?

☐ No, this is my child's first time seeing an orthodontist
☐ Yes, my child has had previous orthodontic treatment
☐ Yes, we are seeking a second opinion

☐ Yes ☐ No Is your child currently under any medical treatment?
Details: _____

☐ Yes ☐ No Is your child currently taking any medication?
Details: _____

☐ Yes ☐ No Does your child have any known allergies?
☐ Sulfa drugs ☐ Penicillin ☐ Local anesthetics (e.g., lidocaine) ☐ Latex ☐ Other: _____
☐ **Nickel / Metal allergy** — *Important: Standard orthodontic brackets and wires contain nickel. Please disclose any known or suspected metal sensitivity so alternative materials can be considered.*
Details: _____

☐ Yes ☐ No Does your child experience pain, clicking, or popping in the jaw?

☐ Yes ☐ No Does your child have habits such as nail biting, thumb sucking, or cheek biting?
Details: _____

☐ Yes ☐ No Have there been any injuries to the teeth or jaw?

☐ Yes ☐ No Have we treated other family members?
Details: _____

☐ Yes ☐ No Has there been any history of the following?
☐ Asthma ☐ Epilepsy ☐ TB ☐ AIDS/HIV ☐ Kidney or Liver Condition ☐ Joint Swelling
☐ Rheumatic Fever ☐ Heart Condition/Pacemaker ☐ Osteoporosis ☐ Other major illness: _____

Birth & Developmental History

Were there any significant complications during pregnancy, delivery, or the neonatal period? ☐ Yes ☐ No
☐ Premature birth (before 37 weeks) ☐ Low birth weight ☐ NICU admission ☐ Other: _____

Has your child experienced any delays in speech, language, or motor development? ☐ Yes ☐ No
If yes, please describe: _____
☐ Currently receiving speech/language therapy ☐ Previously received speech/language therapy ☐ Referred but not yet seen

Ear, Nose & Throat (ENT) History

Has your child had a history of chronic or recurrent ear infections (otitis media)? ☐ Yes ☐ No
☐ Required ear tubes (tympanostomy) ☐ Currently under ENT care

Has your child had a tonsil or adenoid evaluation? ☐ Yes ☐ No ☐ Not sure
☐ Tonsils enlarged or history of recurrent tonsillitis ☐ Adenoids enlarged or obstructive
☐ Tonsillectomy / adenoidectomy previously performed — Approximate date: _____
☐ Currently being managed by an ENT specialist

Level of dental anxiety (for child): ☐ None ☐ Mild ☐ Moderate ☐ Severe

Child's hobbies / sports / activities (important for mouthguard recommendations):

Treatment Preferences

How important are clear aligners (Invisalign)? ☐ Very Important ☐ Somewhat ☐ Not Important
How important are traditional braces? ☐ Very Important ☐ Somewhat ☐ Not Important
How important is a low down payment? ☐ Very Important ☐ Somewhat ☐ Not Important
How important is a low monthly payment? ☐ Very Important ☐ Somewhat ☐ Not Important

Communication Style Preference

When it comes to understanding your child's orthodontic treatment, which best describes you? *(Please select one)*

☐ **Big picture —** I trust the orthodontist's expertise and mainly want to understand the overall treatment timeline and cost. I do not need step-by-step details.
☐ **Full details —** I like to be fully informed and prefer a thorough explanation of each phase of treatment, including how procedures work and what to expect.

** Mandatory field required (Updated 2025)*

Pediatric Sleep Questionnaire

(Airway & Sleep Health Screening)

Date: _____ Name of Child: _____ Date of Birth: _____

Person Completing this Form: _____ Relationship to Child: _____

Instruction: Please answer the following questions about your child IN THE PAST MONTH. "Y" = Yes | "N" = No | "Not Sure" = Not Sure / Don't Know | "Usually" = more than half the time or more than half the nights.

For each item, select YES, NO, or Not Sure	YES	NO	Not Sure
1. While sleeping, does your child:			
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have "heavy" or loud breathing?			
Have trouble breathing, or struggle to breathe?			
2. Have you ever seen your child stop breathing during the night?			
3. Does your child:			
Tend to breathe through the mouth during the day?			
Have a dry mouth on waking up in the morning?			
Occasionally wet the bed?			
Wake up feeling unrefreshed in the morning?			
Have a problem with sleepiness during the day?			
4. Has a teacher or supervisor commented that your child appears sleepy during the day?			
5. Is it hard to wake your child up in the morning?			
6. Does your child wake up with headaches in the morning?			
7. Did your child stop growing at a normal rate at any time since birth?			
8. Is your child overweight?			
9. This child often:			
Does not seem to listen when spoken to directly.			
Has difficulty organizing tasks and activities.			
Is easily distracted by extraneous stimuli.			
Fidgets with hands or feet, or squirms in seat.			
Is "on the go" or often acts as if "driven by a motor."			
Interrupts or intrudes on others (e.g., butts into conversations or games).			

For Office Use Only — Total YES Count: _____

Hawaiian Smiles
ORTHODONTICS

Hawaiian Smiles Orthodontics
New Patient Appointment Policy

At Hawaiian Smiles Orthodontics, we value your time and are committed to a smooth, on-time experience for all of our patients. We send appointment reminders via email and text **7 days** and **3 days** before your scheduled visit. Reply **YES** to confirm or **NO** to reschedule.

Please Note:
If we do not receive a response from you within **48 hours** of your scheduled new patient appointment, your appointment may be **cancelled** after multiple unsuccessful attempts to reach you via email, text, and/or phone call. We encourage you to confirm or reschedule as soon as possible to keep your appointment time reserved.

First Consultation – Rescheduling Policy

- **More than 48 hours notice** = no charge
  - o $50 fee if reschedule or cancelling within/before 48 hours' notice.
  - o A second rescheduling will require a non-refundable deposit of $75, which will be applied toward your future treatment cost.
  - o Failure to attend a third scheduled consultation will result in forfeiture of the deposit, and any subsequent consultations will only be available in a virtual format.

- **Less than 48 hours' notice**
  - o $50 late fee will apply and to reschedule a $75 deposit will be required for 2nd consultation. This amount will be applied toward your future treatment cost.
  - o If you miss this second rescheduled appointment, the deposit will be forfeited, and any future consultations will be conducted virtually only.

Signature: **Date:**

Hawaiian Smiles
ORTHODONTICS

YOUR ORTHODONTIC APPOINTMENTS

***Patient's First and Last Name:**

During active orthodontic treatment, most patients are seen every **8 to 12 weeks**. We schedule most visits during after-school and after-work hours to minimize time away from school and work. A few visits during treatment may require longer appointment times.

- **LONGER APPOINTMENTS**: Some procedures require more time and are scheduled during school/work hours at our Kaneohe and Kona locations, keeping after-school/work slots available for most visits.

- **SHORTER APPOINTMENTS**: Most visits are brief and can be completed at any of our full-service locations.

- **LATE ARRIVALS**: If you arrive 15 or more minutes late, your appointment may need to be rescheduled in order to accommodate other patients who arrived on time. If we are able to see you, please be aware that not everything originally planned for that visit may be completed.

- **ORTHODONTIC EMERGENCIES** (pain, swelling, or bleeding from trauma): After hours or on weekends, please **TEXT or send a picture message to (808) 247-6039**. You will be directed to the appropriate contact for your office location. **No scheduling requests will be taken on this line.** Note: Our office is closed Saturday, Sunday, and most major holidays.

- **REPAIRS** (loose bands/brackets, broken wires, broken retainers): Repair appointments are scheduled during school hours as they take extra time. This keeps our after-school schedule open for routine visits.

- **MISSED OR LATE-CANCELLED APPOINTMENTS**: A **$50 fee** applies to any appointment broken or cancelled with less than 48 hours' notice. Rescheduling may require a wait of 4–6 weeks, which can extend your overall treatment time. Repeat missed appointments may result in loss of scheduling privileges.
  The card on file with our office will be automatically charged.
  If an unexpected emergency occurs, please contact us — we handle each situation individually.

- **EXCESSIVE RESCHEDULING**: Frequent cancellations add to total treatment time. If treatment extends more than 6 months beyond the estimated end date due to rescheduling, Dr. Nayak will assess whether additional monthly fees apply.

- **GENERAL DENTIST VISITS**: Please continue seeing your regular dentist every 6 months for cleanings. Let us know your dental appointment date — we will temporarily remove wires beforehand and replace them right after, so treatment stays on track.

- **WAIMEA / KAMUELA OFFICE PATIENTS**: Due to limited availability at our Waimea/Kamuela location, all appointments exceeding 30 minutes — including the delivery or bonding of Clear Aligners/Invisalign and the bonding of braces — will be scheduled and completed at our Kona office. We appreciate your understanding and flexibility.

- **GRIN AT-HOME MONITORING**: If enrolled in our Grin at-home monitoring program, weekly scans allow us to track progress remotely through the app.
  Visits will be on demand. If we notice any concerns or if you request an appointment, we will schedule one in advance. Please continue submitting weekly scans on time to keep treatment on track.

I have read and agree to the scheduling information above:

***Patient / Parent Signature:** ***Date:**

*(03/2025) *Mandatory field required*

Hawaiian Smiles
ORTHODONTICS

ORTHODONTIC CONSULTATION VIDEO RECORDING CONSENT FORM

Purpose of Video Recording

At Hawaiian Smiles Orthodontics, we offer the option to record your virtual consultation so you and your family can revisit treatment discussions, digital models, X-rays, treatment plans, and Q&A at any time. Recordings may be shared with the patient, parent(s)/legal guardian(s), and other authorized family members — with your consent.

Security and Privacy

Recordings will be:

- Used solely for patient education, medical documentation, and care coordination with authorized family members and healthcare providers.
- NOT used for social media, marketing, or public display.
- Stored securely and encrypted.
- Shared only with individuals you have authorized.
- Deleted upon written request, or after 1 month — whichever comes first. After this period, the recording will no longer be retained.

Consent to Record

☐ I **authorize** Hawaiian Smiles Orthodontics to record my/my child's video consultation for personal reference.
☐ I do **not authorize** the recording of my/my child's video consultation.

Acknowledgment

By signing below, I confirm that:

- I understand the purpose of the recording and how it will be protected.
- I voluntarily consent to (or decline) the recording as indicated above.
- I understand I may withdraw or change my consent at any time without affecting my care.
- I understand that oral confirmation will also be obtained before any recording begins.

***Name of Patient (Child):** _____

Printed Name of Parent / Legal Guardian: _____

***Signature of Parent / Legal Guardian:** _____ ***Date:** _____

6/2025

Hawaiian Smiles
ORTHODONTICS

CONSENT FOR EMERGENCY TREATMENT OF A MINOR

Purpose of This Form

This consent form authorizes Hawaiian Smiles Orthodontics to provide emergency or urgent orthodontic care to your child in the event that a parent or legal guardian cannot be reached prior to treatment. This form does not replace routine informed consent for planned treatment — it applies only to situations requiring immediate intervention to prevent pain, injury, or further harm.

Situations This Consent Covers

- A broken wire or bracket causing laceration or significant irritation to the soft tissues of the mouth.
- An appliance that has become dislodged and poses a risk of ingestion or injury.
- A trauma-related orthodontic emergency occurring on the premises.
- Acute pain requiring interim management pending parent/guardian contact.

What We Will Do

- Make every reasonable attempt to reach the parent(s) or legal guardian(s) listed on this form before proceeding.
- Provide only the minimum care necessary to address the immediate concern safely.
- Document all emergency care provided and notify the parent/guardian as soon as contact is made.
- Refer to an emergency facility if the situation is beyond the scope of this office.

Emergency Contact Priority

In the event of an emergency, we will attempt to reach contacts in the following order:

Primary Emergency Contact — Name: **Phone:**

Authorization

I/We, the undersigned parent(s) or legal guardian(s) of the minor patient named below, hereby authorize Hawaiian Smiles Orthodontics and its clinical staff to administer emergency orthodontic care to my/our child in circumstances where immediate intervention is necessary and a parent or guardian cannot be reached in a timely manner. I/We understand that:

- This authorization covers emergency care only, not routine or elective treatment.
- We will be notified of any care provided as soon as reasonably possible.
- This authorization remains in effect for the duration of the patient's enrollment at this practice unless revoked in writing.
- This form does not limit our right to be involved in planned treatment decisions.

***Name of Patient (Child):**

Name of Parent / Legal Guardian (Print): **Relationship:**

***Signature of Parent / Legal Guardian:** ***Date:**

Name of Second Parent / Legal Guardian (Print — if applicable): **Relationship:**

Signature of Second Parent / Legal Guardian: **Date:**

*2025 *Mandatory field required*

Hawaiian Smiles
ORTHODONTICS

SOCIAL MEDIA & PHOTOGRAPHY RELEASE FORM

What this form means: By signing (and **not** checking the opt-out box), you give Hawaiian Smiles Orthodontics permission to use before/after photos, videos, and images from your child's treatment for social media, advertising, our website, and patient education. You are **not** required to consent — declining will **not** affect your child's care in any way.

Full Terms:

I consent to the use of my child's personal image and likeness — including images depicting the treatment provided — by Hawaiian Smiles Orthodontics for any lawful purpose, including treatment records, advertising our services (including via social media and electronic media), illustration, and publication for educational or marketing purposes.

I relinquish all rights to any image of my child obtained by photographic or digital means by Hawaiian Smiles Orthodontics during the course of treatment. I understand I am not entitled to compensation for the use of my child's image in any advertising, promotional, or educational materials.

I understand that any image or likeness of my child may be altered before use. I agree that I have no right to be consulted about or to approve such alterations before the image is used.

Hawaiian Smiles Orthodontics will make reasonable efforts to safeguard privacy as required by applicable law, including HIPAA. However, Hawaiian Smiles Orthodontics cannot guarantee complete privacy once an image is shared publicly or by third parties.

Hawaiian Smiles Orthodontics may include information about my child's health condition — such as diagnosis, course of treatment, or age — in describing the treatment shown in any image.

I understand that Hawaiian Smiles Orthodontics has not and will not condition my child's treatment upon authorization of the use of their image or likeness.

☐ **I DECLINE — I do not want my child photographed or videotaped for social media, marketing, or educational purposes.**

***Name of Patient (Child):** _____

Printed Name of Parent / Legal Guardian: _____

***Signature of Parent / Legal Guardian:** _____ ***Date:** _____

*03/2025 *Mandatory field required*

Hawaiian Smiles
ORTHODONTICS

ORTHODONTIC X-RAY / RADIOGRAPH CONSENT FORM

Purpose of X-Rays in Orthodontic Care

X-rays (radiographs) are an essential part of orthodontic diagnosis and treatment planning. They allow Dr. Nayak to:

- Assess the position of teeth, roots, and supporting bone structures.
- Identify dental or skeletal problems that may affect treatment.
- Monitor progress and confirm healthy tooth movement throughout treatment.
- Detect conditions not visible during a routine clinical examination.

Types of X-Rays We May Take

- **Panoramic (OPG)** — A full-mouth image showing all teeth, jaws, sinuses, and surrounding bone.
- **Cephalometric** — A side-profile X-ray of the skull used for growth analysis and treatment planning.
- **Bitewing X-rays** — Images of the back teeth; typically taken at your general dentist.
- **Periapical X-rays** — Show the full length of individual teeth, from crown to root tip.
- **CBCT (3D Cone Beam CT)** — A three-dimensional scan taken only when clinically necessary for complex cases.

Radiation Safety

We use **digital X-ray technology**, which delivers significantly lower radiation exposure than traditional film X-rays. All equipment is regularly inspected and calibrated. Lead aprons and thyroid collars are available upon request.

Consent

☐ I **consent** to X-rays/radiographs being taken as clinically determined necessary by Dr. Nayak and the clinical team.

☐ I do **not consent** to X-rays/radiographs. *Note: Declining X-rays may limit our ability to provide a complete diagnosis and safe treatment plan.*

By signing below, I confirm that:

- I understand why X-rays are used and have had the opportunity to ask questions.
- X-rays will only be used for diagnosis and treatment purposes.
- I may ask about the type of X-rays to be taken at any time.
- I may withdraw this consent in writing at any time, understanding it may affect the care received.
- If treatment is not started at our office, a records release fee of $250 will apply for X-rays to be released to me.

Records & X-Ray Release Policy

Orthodontic records, including X-rays, are the property of Hawaiian Smiles Orthodontics. There is no charge for X-rays taken as part of your child's records when treatment is completed at our office. However, if orthodontic treatment is not initiated at our office and you request that X-rays or records be released directly to you or transferred to another provider, a **records release fee of $250** will be collected prior to the release of any records. We reserve the right to charge this fee and will not release records until it has been paid in full.

By signing above, you acknowledge that you have read and understood this policy.

***Child's Name:** **Date of Birth:**

Printed Name of Parent / Legal Guardian:

***Signature of Parent / Legal Guardian:** ***Date:**

*2025 *Mandatory field required*

HAWAIIAN SMILES ORTHODONTICS
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. **Please review it carefully.** The privacy of your health information is important to us.

YOUR RIGHTS

You have the right to:

- Obtain a copy of your paper or electronic medical record.
- Request that your medical record be corrected.
- Request confidential communications.
- Ask us to limit the information we share.
- Receive a list of those with whom we have shared your information.
- Receive a copy of this privacy notice at any time.
- Choose someone to act on your behalf.
- File a complaint if you believe your privacy rights have been violated.

YOUR CHOICES

You have some choices in how we use and share your information when we:

- Tell family and friends about your condition.
- Provide disaster relief services.
- Raise funds.

We will never use or share your information for marketing purposes or sell it without your written permission.

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for your services.
- Help with public health and safety.
- Do research.
- Comply with the law.
- Work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.

YOUR RIGHTS — IN DETAIL

Get a copy of your medical record

You can ask to see or receive a copy of your medical record and other health information. Submit your request in writing. We will respond within 30 days. A reasonable cost-based fee may apply.

Ask us to correct your medical record

You can ask us to correct information you believe is incorrect or incomplete. If we deny your request, we will inform you in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way or to send mail to a different address. We will honor all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information. We are not required to agree, but if we do, we are bound by it.

Get a list of those with whom we've shared your information

You can request an accounting of disclosures made in the past six years. We provide one free accounting per year.

Get a copy of this notice

You can request a paper copy of this notice at any time, even if you agreed to receive it electronically.

Choose someone to act for you

If you have given someone medical power of attorney or they are your legal guardian, that person may exercise your rights. We will verify their authority before acting.

File a complaint

Contact our Privacy Officer (listed at the end of this notice) or file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights at 1-877-696-6775 or www.hhs.gov/ocr/privacy/. We will not retaliate against you for filing a complaint.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will notify you promptly if a breach occurs that may have compromised your health information.
- We must follow the duties and privacy practices described in this notice and provide you with a copy.

- We will not use or share your information other than as described here unless you give us written permission.

CHANGES TO THIS NOTICE

We can change the terms of this notice at any time. Changes will apply to all health information we have about you. The updated notice will be available in our office and upon request.

This Notice is in effect as of May 1, 2023.

Our Privacy Officer is Nicole Fernandez, Administrative Lead. Contact her at: Phone (808) 247-6039 | Fax (808) 247-3643 | Email **Admin@hawaiiansmilesortho.com**. We will **never** sell or market your personal information.

Hawaiian Smiles
ORTHODONTICS

Notice of Privacy Practices — Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding the privacy of my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct treatment and follow-up care among the providers involved.
- Obtain payment from third-party payers such as insurance carriers.
- Conduct normal healthcare operations.

I have received, read, and understand the *Notice of Privacy Practices*. I understand that Hawaiian Smiles Orthodontics has the right to change its Notice of Privacy Practices and that I may request a current copy at any time.

I understand that I may request in writing that you limit how my private information is used or disclosed. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound by them.

***Patient Name (Child):**

Name of Parent / Legal Guardian: **Relationship to Patient:**

***Parent / Legal Guardian Signature:** ***Date:**

Requires Parent/Guardian's signature.

For Office Use Only

I attempted to obtain the patient's (or guardian's) signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below.

Staff Name (Print): **Date:**

☐ Individual refused to sign.
☐ Communication barriers prevented obtaining the acknowledgement.
☐ An emergency situation prevented us from obtaining acknowledgement.
☐ Other (please specify):

(03/2023)