

## **GATEWAY PEDIATRIC DENTISTRY PERSONAL INFORMATION CONSENT**

We are committed to protecting the privacy of our patient's personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and email addresses. (Collectively referred to as "Contact Information".) Contact information is collected and used for the following purposes:

- \* To open and update patient files.
- \* To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- \* To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- \* To send reminders to patients concerning the need for further dental examination or treatment and/or appointment confirmations.
- \* To send patients informational material about our dental practice.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- \* To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
- \* To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to use obtaining the second opinion.
- \* To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.

\* To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.

\* To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. IF this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

To comply with the Canadian Anti-Spam Legislation (CASL) that is in effect as of July 1, 2014, our dental office would like to have your express consent to continue communicating with you and providing you with important information from us. We are committed to never sending spam emails and our privacy policy will always protect your electronic information. We do send information, communication via email and text for our patients' convenience.

If you decide to opt in and continue receiving emails, please know that you may opt out at any time and withdraw your consent.

\_\_\_ YES I give consent to receive communication and appointment confirmations via email and/or text.

\_\_\_ NO I do not give consent. I prefer to receive telephone confirmations.

I consent to the collection, use and disclosure of my personal information as set out above.

Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_