

PRIVACY PRACTICE AND OFFICE POLICY ACKNOWLEDGEMENT

PLEASE CAREFULLY REVIEW OUR PRIVACY PRACTICES AND OFFICE POLICIES BELOW.

We have available to you a copy of our privacy practices effective 02-16-26.

We have designed our office with children in mind. We use an open and inviting atmosphere to be more comfortable for children. Due to the nature of this unique design to accommodate the needs and comfort of our patients, we understand that you may request extra efforts for confidentiality of information and/or restrictions. We respect your concerns and will make every effort to adjust accordingly, while maintaining superior patient-centered care.

We have provided a space below for you to express your concerns or wishes pertaining to communication and consent. If you have any objections that you would like to discuss or any individuals that you DO NOT give us consent to communicate about the patient's private health information, please enter it below.

- We will never market or sell personal information
- We may use and share your health information to run our organization, improve your care and contact you when necessary. We may use or disclose your information to text or call you pertaining to, but not limited to: appointment reminders, appointments and treatment recommendations, payment activities, etc.
- We may use or disclose, as needed, your protected health information to conduct certain business and operational activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you and/or your child by name in the waiting room.
- Unless you object, we may disclose the patient's health information to a family member or close friend who is involved in the patient's healthcare, or someone who helps to pay for the care. In your absence, we assume there are no objections of communication with the person entrusted with their care at that time. Any objections can be listed below.
- You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on the patient's behalf (parent, patient representative, legal guardian). We will not be bound unless our agreement is in writing.
- You have the right to request that we communicate with you confidentially about your protected health information by alternative means or alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you. You can also ask your healthcare provider to speak with you in private outside the presence of other patients- just ask them.
- We may use photographs of you or your child, with or without names, for any lawful purpose. Examples include for such purposes of publicity, illustration, social media, advertising and web content. You have the right to object to this or these terms.

It is our office policy that the patient be accompanied by a parent/legal guardian for the patient's initial visit and for any restorative treatment appointments thereafter, unless consent is given by the doctor. If consent by the doctor is given, a signed permission form ([CONSENT FOR ACCOMPANIMENT OF A MINOR](#)) must be completed by the parent/legal guardian.

For routine/preventative appointments (excluding the initial visit to our office), the parent/legal guardian can authorize individuals to act on their behalf by signing consent via the permission form ([CONSENT FOR ACCOMPANIMENT OF A MINOR](#)).

This consent allows the authorized individual to discuss any matters pertaining to the appointment at hand and scheduling of future appointments, but consent for treatment by the parent/legal guardian must still be given for any future restorative treatment.

Accompaniment of an authorized individual does not waive the responsibility for any payment that is required for the services rendered at that appointment. Please complete the [CONSENT FOR ACCOMPANIMENT OF A MINOR](#) attached to grant permission for your child to be accompanied at future dental appointments by someone other than you.

For more information regarding our privacy policy, contact us:

Dr Kenneth W Johnson DDS
662-840-8540
tinyteeth@drkennethjohnson.com

Please list any specific objections that you have regarding any contact pertaining to the patient, their appointments and the discussion and consent of your child's health information and/or dental treatment.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please sign below:

- To acknowledge that you have been offered a copy of our Notice of Privacy Practices and consent to disclosure of your/your child's health information that we deem necessary to carry out treatment, payment activities and healthcare operations.
- To acknowledge that you are aware of our office policies regarding the patient's (a minor) accompaniment to appointments.
- To acknowledge that you are aware that you have the right to request any additional restrictions or confidentiality accommodations.
- To agree to the use of photographs of you or your child for use as described above.
- To confirm that you are the legal guardian of the patient and can legally make decisions on their behalf.

SIGNATURE OF LEGAL GUARDIAN: _____

PRINTED NAME: _____ DATE: _____

PATIENT: _____ DATE OF BIRTH: _____

PATIENT: _____ DATE OF BIRTH: _____

PATIENT: _____ DATE OF BIRTH: _____

PATIENT: _____ DATE OF BIRTH: _____

PATIENT: _____ DATE OF BIRTH: _____