PATIENT CONSENT FORM: COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Privacy of your personal health information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. It is important to us to provide this service to our patients.

In this office, Dr. Jyoti Datta [Insert Name] is the contact person for personal health information related matters.

All staff members who come in contact with your personal health information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what our office is doing to ensure that:

- only necessary information is collected about you;
- we only share your information with your consent;
- storage, retention and destruction of your personal health information complies with existing legislation, and privacy protection protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

How Our Office Collects, Uses and Discloses Patients' Personal Health Information

Our office understands the importance of protecting your personal health information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose personal health information about you for the following purposes:

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to assess your health needs
- to provide health care
- to advise you of treatment options
- to enable us to contact you
- to establish and maintain communication with you
- to offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally
- to communicate with other treating health care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists
- to allow us to maintain communication and contact with you to distribute health care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit dental claims for third party adjudication and payment
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- to comply with agreements/undertakings entered into voluntarily by the member with the Royal College of Dental Surgeons of Ontario, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- to permit potential purchasers, practice brokers or advisors to evaluate the dental practice
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- to deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials for the Health Professions Appeal and Review Board (HPARB)
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance.

Your personal health information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA.

You may withdraw your consent for use or disclosure of your personal health information at any time.

Patient Consent

I have reviewed the above information that explains how your office will use my personal health information, and the steps your office is taking to protect my information.

I agree that Lighthouse Dental Care can collect, use and disclose
[Insert Name Of Dentist/Health Profession Corporation]

personal health information about _____ as
[Patient Name]

set out above in the information about the office's privacy policies.

_____ _____
Signature Date

_____ _____
Print name Signature of witness

COVID-19 screening and dental treatment consent form

Patient Name *

First Name | Middle Name | Last Name

I, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- FEVER (feeling hot to touch, a temperature of 100 degrees fahrenheit or higher)
- CHILLS
- COUGH that's new or worsening (continuous, more than usual)
- BARKING COUGH, making a whistling noise when breathing ('CROUP')
- SHORTNESS OF BREATH (out of breath, unable to breathe deeply)
- SORE THROAT
- DIFFICULTY SWALLOWING
- RUNNY NOSE (not related to seasonal allergies or other know causes or conditions)
- NASAL CONGESTION (not related to seasonal allergies or other known causes or conditions)
- LOSS OF SENSE OF SMELL
- PINK EYE (conjunctivitis)
- HEADACHE that's unusual or long-lasting
- DIGESTIVE ISSUES (nausea/vomiting, diarrhea, stomach pain)
- MUSCLE ACHES
- EXTREME TIREDNESS THAT IS UNUSUAL (fatigue, lack of energy)
- FALLING DOWN MORE THAN USUAL
- FOR YOUNG CHILDREN & INFANTS: Sluggishness or lack of appetite

I verify that I have not traveled outside of Ontario in the past 14 days and have not been in touch with anyone with covid/potential covid in the last 14 days.

Thank you for doing your part in keeping everyone safe. Please note the following:

- wear a mask when entering the dental office
- sanitize your hands immediately upon arrival
- maintain social distancing from other patients
- have your temperature taken by our team members
- not have any accompaniment except small child/caregivers/translators

Signature *

Clear

Date *

Date

Submit

HIPAA COMPLIANT