Wilson & Kim orthodontics SMILE SCHOLARSHIPS

Application Checklist

PLEASE ENSURE ALL DOCUMENTS ARE INCLUDED — WE WILL NOT NOTIFY YOU IF YOUR PACKET IS INCOMPLETE

☐	Application – Completed, as directed, in black or blue ink	☐	Dental Referral Form
☐	Contract – Read and signed by parent(s)/guardian(s) and applicant	☐	Report Card (if enrolled in school)
☐	Applicant Questionnaire – Handwritten by the applicant	☐	Medical Authorization for non-parental guardians
☐	Household Information	☐	Patient Information form
☐	2 Letters of Recommendation from community leaders or teachers, with contact information included (You may submit additional letters if you wish written by family/friends, however the 2 required letters must NOT be from family/friends.)		
☐	Photos (minimum of 3) – See sample photos and details attached, photos must be in clear focus, not blurry		

SMILE SCHOLARSHIP for ORTHODONTIC TREATMENT at WILSON & KIM ORTHODONTICS

We are proud to provide orthodontic care every year to children and young adults with financial challenges, special situations, and orthodontic needs.

Scholarships are limited and based on financial need, orthodontic need, and a complete and accurate application. Selection is based on the information provided within the application packet (i.e. commentary, personal essay, character, and accompanying letters of recommendation, dental referral form, report card, photos), as well as in-person evaluation/screening appointments.

QUALIFICATIONS

Applicant must…

- Be between the ages of 10 – 21*
- Be experiencing a financial hardship
  (If chosen, proof of income or financial hardship will be **required** prior to treatment:
  W-2, Income tax return, SSI award letter, TANF grant letter, etc.)
- Have "good" dental hygiene practices and a dental hygiene check-up in the past 6 months
- Have a functional and/or aesthetic need for braces
- Currently be enrolled in school (if age appropriate for 4th-12th grade)
- Demonstrate a positive attitude
- Follow and abide by treatment plan set forth by our doctors
- Demonstrate a willingness to get involved in the community through extracurricular activities and/or volunteer service
- Have positive letters of recommendation from at least two community leaders and/or teachers

**We may consider exceptions under special circumstances. Please submit a letter to our office to explain your situation.*

***Please do not schedule an exam prior to the application deadline since an exam will be part of the selection process if you are chosen to proceed to that phase.*

SUBMIT COMPLETED APPLICATION AND REQUESTED DOCUMENTS BY MAY 1st TO:

Wilson & Kim Orthodontics
7250 Redwood Blvd., Ste. 107
Novato, CA 94945
(415) 878-0240

IF YOUR APPLICATION IS INCOMPLETE, IT WILL NOT BE CONSIDERED IN THE SELECTION PROCESS.

ORTHODONTIC SCHOLARSHIP APPLICATION FORM

If applicant is under the age of 18, this page is to be completed by parent/guardian.

INFORMATION ABOUT THE APPLICANT (THE APPLICANT IS THE CHILD SEEKING TREATMENT, NOT THE PARENT/GUARDIAN)

Applicant's Last Name:	First:	Middle:
Today's Date:	Applicant's Primary Dentist:	

Has applicant ever applied for this scholarship before?	YES	NO	If so, what year(s)?	

Applicant's Date Of Birth (MM/DD/YYYY):		Applicant's Age:		Applicant's Gender:	MALE	FEMALE

Is applicant currently enrolled in school:	YES	NO	What grade (if applicable):		What is your GPA (if applicable):

Name of School:	School Address (City, State, Zip Code):	School Phone:	( )

Is applicant currently wearing braces?	YES	NO

If applicant is over the age of 16, what is her/his plans over the next 5 years (Moving, College, etc.):

Home Address:	City:	State:	Zip:	Home phone:	Cell phone:
				( )	( )

How did you hear about Wilson & Kim Orthodontics Smile Scholarship Program?

There are many reasons why people get braces; please select the following that apply or add your own:

	Discomfort while eating/drinking		Jaw and/or mouth pain		She/he looks down when talking
	Speech Impediment		She/he gets teased about her/his teeth		She/he covers her/his mouth when she/he laughs
	It's hard to clean her/his teeth well		She/he is embarrassed to smile		She/he has a hard time sleeping/Sleep apnea

PARENT / GUARDIAN INFORMATION

Parent / Guardian's Name:	Parent / Guardian's Occupation:	Parent / Guardian's Employer:	Employer phone no.:
			( )
Parent / Guardian's Name:	Parent / Guardian's Occupation:	Parent / Guardian's Employer:	Employer phone no.:
			( )

Have any other children in the household been treated through our Smile Scholarship Program (If so, list their names)?

Have any other children in the household had orthodontic treatment (If so, list their names)?

Are any other children in the household current or past patients of our office (If so, list their names)?

Parent / Guardian Phone: ( )	Parent / Guardian Email:

***** It is important to understand that orthodontic treatment can span over several years. Can you make your child's treatment a priority?*****

What is your primary means of getting the applicant to appointments on time? Also, what is your back up plan for transportation (Bus, Friends or Family, Taxi)?

Are there plans of relocating the family in the next two years? If so, where?

What is most important to you about your son/daughter receiving this scholarship?

Attention Non-Parental Guardians:

In order to be considered, you MUST attach copy of medical authorization. If the applicant is in state custody, submit a copy of medical card and consent form.

IF YOUR APPLICATION IS INCOMPLETE, IT WILL NOT BE CONSIDERED IN THE SELECTION PROCESS.

HOUSEHOLD INFORMATION

If applicant is under the age of 18, this page is to be completed by parent/guardian.

How many people are in your household?	TOTAL:		Number of Adults:		Number of children:	

PRIMARY SOURCES OF INCOME

Name:		**Name:**	
Employer Name:		Employer Name:	
Hourly wage/Salary:		Hourly wage/Salary:	
Hours worked per week:		Hours worked per week:	
Gross Income per month:		Gross Income per month:	

OTHER SOURCES OF INCOME

Is anyone receiving or going to receive the following:

Child Support or Alimony (please circle)	Yes	No	Amount:		Frequency:	
Unemployment	Yes	No	Amount:		Frequency:	
Other Income	Yes	No	Amount:		Frequency:	

ARE YOU CURRENTLY RECEIVING ANY OF THE FOLLOWING BENEFITS?

Type of Benefit	**Receiving**		**Amount**		**Type of Benefit**	**Receiving**	
Food Stamps	Yes	No			School Lunch Program	Yes	No
WIC	Yes	No			State Provided Childcare	Yes	No
TANF	Yes	No			State Provided Healthcare/Dental	Yes	No

FINANCIAL HARDSHIP

What are the circumstances surrounding your financial hardship?

IF YOUR APPLICATION IS INCOMPLETE, IT WILL NOT BE CONSIDERED IN THE SELECTION PROCESS.

APPLICANT QUESTIONNAIRE

HANDWRITTEN BY THE APPLICANT ONLY. Each question must be answered in essay format at least 5 to 7 sentences in length. Attach additional pages if needed.

What would it mean to you if you received orthodontic treatment through Wilson & Kim Orthodontics Smile Scholarships Program? Why do you feel you are a deserving candidate for one of our Smile Scholarships?

Tell us about yourself. What do you like to do? What extracurricular activities do you participate in? Do you do any community service or volunteer work? What are your goals and aspirations?

Tell us about your family. How many siblings do you have, do they live with you, what do you like to do together?

Why do you want braces? What prevents you from getting braces now? How do you feel about your smile now? How do you think braces will improve your life now and in the future?

How will you **"Pay it Forward"**? This is a gift you would be receiving from Wilson & Kim Orthodontics; our office has chosen to help children and young adults with the gift of a healthy, beautiful smile and will be contributing time and money to treat the scholarship recipients.

If you had a chance to do a favor for another person or organization, without any expectation of being paid back, what would you do and why?

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AGREEMENT FOR ORTHODONTIC TREATMENT

If _____(Patient) is selected to receive a Smile Scholarship for orthodontic treatment at Wilson & Kim Orthodontics, then this will serve as the treatment agreement. The decision to award scholarships for orthodontic treatment is largely subjective and based on the complete application that was submitted. Orthodontic treatment will be provided by Wilson & Kim Orthodontics.

I, _____, (Responsible Party), agree that I will commit to bringing _____(Patient) to all scheduled appointments. I understand that Wilson & Kim Orthodontics is committed to patient care and agree that I will cooperate with the following requirements in order to maintain this orthodontic scholarship:

- Appointments will be scheduled in the morning between 9am and 1pm (at the discretion of the office)
- Keeping appointments (You cannot have more than two (2) missed appointments, without providing one (1) business day's notice to the office)
- Excellent oral hygiene (brushing and flossing)
- Proper eating habits (More than two (2) loose brackets may determine that cooperation is not sufficient)
- Wearing of elastics (rubber bands), headgear, and springs, as appropriate

_____ **(Initial)** Failure to follow all of the above requirements and/or inappropriate behavior during treatment is grounds for termination of your scholarship, which would result in Wilson & Kim Orthodontics removing all appliances/braces and discontinuing treatment.

_____ **(Initial)** Consent: Like any treatment of the body, much of orthodontic success depends on the understanding and cooperation of the patient. As a patient of Wilson & Kim Orthodontics: I will ensure I act in my own (or my child's) best interests by following the doctor(s) professional advice. I will ensure scheduled appointments are kept, allowing treatment to proceed in an orderly and uninterrupted manner. I will be forthright regarding administrative questions such as health history, financial or insurance information, employment history, and contact information (keeping the practice updated at all times of any changes to any of these items.) I will agree to pay for professional services rendered in the agreed-upon manner.

General dental care and check-ups are the responsibility of the patient's responsible party. We advise patients to see their general dentist every three (3) to six (6) months during active orthodontic treatment. ***Please notify us promptly if you change dentists so that our treatment correspondence will be sent to the correct doctor.***

If any problems or questions arise that will compromise my commitment to these requirements, I will inform a member of the Wilson & Kim Orthodontics team immediately. If any disagreement arises and is unresolved by direct communication with a member of the Wilson & Kim Orthodontics team, Wilson & Kim Orthodontics may terminate treatment.

I understand that **neither** Wilson & Kim Orthodontics, **nor** any of its doctors are affiliated with any government program or organization. Treatment provided by Wilson & Kim Orthodontics is solely a gift to the scholarship winner.

This scholarship will be awarded for an initial phase of orthodontic treatment only. Any further additional orthodontic treatment that is recommended by Wilson & Kim Orthodontics will be subject to additional fees.

I understand that this agreement is in addition to all other agreements with Wilson & Kim Orthodontics.

_____ **(Initial)** Wilson & Kim Orthodontics may recommend an oral surgery procedure that will be completed complimentary by oral surgeon, Dr. Mahr Elder, at his office in Novato. There will be no out of pocket expense by you; however, Dr. Elder's office may submit a claim to your insurance company for reimbursement to Dr. Elder for the procedure.

_____ **(Initial)** I hereby give Wilson & Kim Orthodontics the right and permission to publish, copyright and use pictures/x-rays/videos that include the patient and/or family of this agreement, in whole or in part. Pictures/x-rays/videos may be used for educational or promotional purposes. If the person photographed is under 18, I certify that I am his or her parent or legal guardian and I give my consent without reservation to the foregoing on his or her behalf.

Applicant (Potential Patient) Name: _____Responsible Party Name: _____

Responsible Party Signature: _____Date: _____

POTENTIAL RISKS & LIMITATIONS OF ORTHODONTIC TREATMENT

While a pleasing smile, more balanced face, and healthier bite are widely appreciated; orthodontic treatment is an elective procedure. And like any other treatment of the body, it has inherent risks and limitations. Please read the following information carefully.

1. **Cooperation:** Patient cooperation is the most important factor in completing treatment on time. Insufficient wearing of elastics, removable appliances, or headgear; broken appliances, missed appointments, and poor oral hygiene prevent the desirable results we all anticipate. Lack of cooperation is the most common cause of excessive treatment time, increased fees, and disappointing results.
2. **Decalcification and Cavities:** Good oral hygiene is a must during orthodontic treatment. Tooth discoloration and decay can occur if patients eat foods containing excessive sugar and/or if they do not brush their teeth properly. Inadequate cleaning can also cause gum disease, and loose brackets and bands. Although gum problems can occur when not wearing braces, the risk is greater during orthodontic treatment.
3. **Periodontal Problems:** Proper brushing and flossing can usually prevent swollen, inflamed and bleeding gums. Periodontal disease is most often caused by the accumulation of plaque and debris around the teeth and gums. However, unknown causes can also lead to progressive loss of supporting bone and gums. This most frequently occurs in patients with a tendency toward gum disease with or without braces. If periodontal problems become uncontrollable, orthodontic treatment may have to be discontinued prior to completion.
4. **Root Resorption:** Some patients are prone to tooth roots shortening during orthodontic treatment. Under healthy conditions, shortened roots are no problem. However, combined with significant gum or supporting bone problems, the longevity of the involved teeth may be threatened.
5. **TMJ Problems:** Patients with bad bites have a high potential for TMJ (jaw joint) problems, which may become evident during or after orthodontic treatment. TMJ problems may include jaw pain, ear pain, headaches, neckaches, etc. Orthodontic treatment may help remove the dental causes of TMJ problems, but has no effect on non-dental causes. An equilibration of the biting surfaces of the teeth, long-term use of an occlusal splint, or TMJ surgery may be necessary after orthodontic treatment. Remember, the majority of people with TMJ problems have never had orthodontic treatment.
6. **Root Canals:** A tooth previously injured by trauma or a large filling can die over a period of time with or without orthodontic treatment, and may result in the tooth darkening. This condition, seldom due to orthodontics alone, may require root canal treatment.
7. **Relapse:** Shifting or settling of teeth following treatment and retention often occurs in varying degrees. Some undesirable changes may include rotations, crowding of the lower front teeth, spaces at extraction sites, and spaces between upper front teeth. The eruption of wisdom teeth, previously rotated teeth, mouth breathing, and uncontrolled muscle habits are the most frequent causes. The best way to minimize undesirable changes is to wear retainers every night or a few evenings each week for an indefinite period.
8. **Digit Habits:** Continued finger or thumb sucking and incorrect swallowing may extend treatment time. Uncontrolled muscle habits may also cause undesirable tooth shifting following treatment. If significant, re-treatment involving an additional fee may be necessary.
9. **Undesirable Jaw Growth:** Occasionally, insufficient or excessive jaw growth can limit the desired results. On rare occasions, we may need to recommend a treatment plan change to include extractions or jaw surgery. If substantial undesirable growth changes occur after active treatment, re-treatment at an additional fee may be needed.
10. **Impacted Teeth:** Various problems may be encountered during attempts to move an impacted tooth, and may lead to periodontal problems or the loss of the tooth. Occasionally, the tooth becomes trapped under another tooth and the extraction of one of the teeth becomes necessary. Rarely, the impacted tooth fails to move even when there is room and it must be extracted, which may require a bridge or implant replacement.
11. **Oral Surgery:** Sometimes, tooth removal or oral surgery is necessary in conjunction with orthodontic treatment, especially to correct severe jaw imbalances. Oral surgery presents rare life-threatening risks and potential disabilities. Discuss these risks with your oral surgeon and family dentist before deciding to proceed with surgery.
12. **Headgear:** If a headgear is pulled out with the elastic force still attached, the metal part may snap back and injure the face, eyes, etc. Safety devices have been developed to prevent this, but injury may still be caused by careless or improper use.
13. **Ceramic Brackets:** Ceramic brackets may cause excessive wearing of tooth enamel. Also, ceramic brackets are more brittle than steel and may break. These fractured brackets may be swallowed or inhaled, and since they do not appear on x-rays, are difficult for a physician to locate.
14. **Allergies:** Allergies to orthodontic materials may occur during orthodontic treatment. Known allergies can be avoided, but if they are unknown to you, it is impossible to predict any reaction. People who have other allergies are more prone to have allergies to orthodontic materials.
15. **Unusual Occurrences:** Unusual occurrences such as swallowing an appliance, bracket, band, or the end of an archwire; dislodging a restoration, or formation of an abscess or a cyst may occur. These occurrences are extremely rare.
16. **Treatment Time:** The time required to complete treatment may exceed the original time estimate. Most often, treatment is delayed due to

poor cooperation, poor oral hygiene, missed appointments, or unusual growth patterns. Occasionally it is in the best interest of the patient to discontinue treatment and place retainers even though treatment has not achieved the desired results.

17. **Necessary Dental Work:** All necessary dentistry must be completed prior to starting orthodontic treatment. Also, the patient must maintain regular dental checkups every six months during treatment. Adults must visit their dentist for scaling and cleaning every three to six months during treatment, according to their needs.

I have read and understand the above information. I authorize necessary orthodontic treatment for the applicant named below, if she/he becomes a patient of Wilson & Kim Orthodontics.

Applicant (Potential Patient) Name: _____Responsible Party Name: _____

Responsible Party Signature: _____Date: _____

APPLICANT PHOTOS

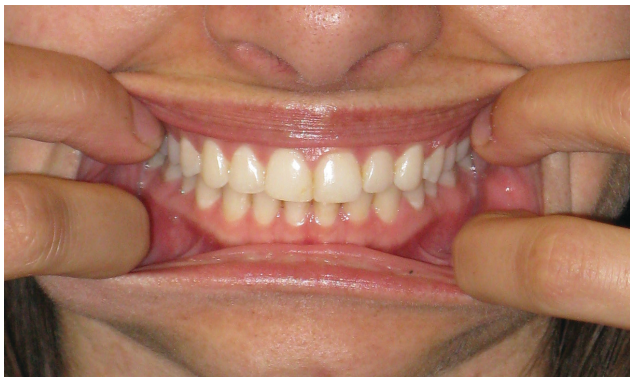
Please attach at least 3 photos of applicant. Photos MUST be in clear focus, not blurry.

IMPORTANT NOTE: For ALL photos, make sure the applicant's teeth are POSITIONED IN THEIR NORMAL BITE. The normal bite is when the back teeth are touching AND the lower jaw is as far back as possible. Make sure the applicant DOES NOT push their lower jaw forward.

1) 5"x7" front view with full smile and teeth showing (teeth should be touching in normal bite)
2) 5"x7" profile view with mouth closed (teeth should be touching in normal bite)
3) 5"x7" close up view of teeth with cheeks pulled apart (teeth should be touching in normal bite)

Sample Photo #1

Sample Photo #2



Sample Photo #3

DENTAL REFERRAL FORM

To be filled out by the applicant's dentist. This form is to be completed prior to submitting application.

Dear Dental Care Provider,

Your patient is applying for an orthodontic scholarship. ***If selected***, the patient will receive free braces through **Wilson & Kim Orthodontics' Smile Scholarships Program**. As the child's dental care provider, it is very important we receive feedback from you in regards to your patient so we can determine whether or not they will be a good candidate for our program. If the form is incomplete, the application cannot be included in the selection process.

Patient's Last Name:		**First:**		**Middle:**
Dentist's Last Name:		**First:**		**Middle:**
Dentist's Address:	Street:	City:	State:	Zip:
Dentist's Contact Info:	Office Ph:	Alternate Ph:	Email:	

General Information:

Does the patient need restorative work at this time?				Yes	No
Does the patient have good oral hygiene?				Yes	No
When was the last time the patient had a dental cleaning with your office?					
How long have you been treating the patient?					
Does the patient have a positive and respectful attitude?					
Does the patient keep appointments and arrive on time: (please circle one)	Never	Rarely	Sometimes	Mostly	Always
Do you have any functional/aesthetic concerns or additional comments?					

Dentist's Signature _____ Dentist's Name _____ Date _____

IF YOUR APPLICATION IS INCOMPLETE, IT WILL NOT BE CONSIDERED IN THE SELECTION PROCESS.

Wilson & Kim orthodontics

415.878.0240 • info@WilsonKimOrthodontics.com
7250 Redwood Blvd., Ste. 107 • Novato, CA 94945
A Partnership of Professional Corporations

Confidential Patient Information

Legal First Name:_____
Legal Last Name: _____
Address: _____
City: _____State: ____ Zip:_____
Birthdate: _____ ☐Male ☐Female
Dentist: _____
Dentist's Address: _____
_____

Emergency Contact:
Name of nearest relative NOT living with you:
_____
Emergency Contact Phone: _____
Relationship to Patient: _____

How did you hear about our office?

☐ Dentist: _____ ☐ Patient:_____ ☐ Parent of Patient:_____

☐ Yelp ☐ Facebook ☐ Google ☐ Ad: _____ ☐ Other: _____

The American Association of Orthodontists recommends all children have a check-up with an orthodontist by age 7.
We will send you a reminder when a sibling is reaching age 7 to come in for a complimentary exam.

Sibling Name_____ Birthdate: _____ ☐Male ☐Female

Sibling Name_____ Birthdate: _____ ☐Male ☐Female

Responsible/Financial Party

(complete blue items below if you are an adult patient)

Relationship to Patient:
☐ mother ☐ father ☐ other_____
First Name: _____
Last Name: _____
Address: _____
City: _____State: ____ Zip:_____
Primary Phone: _____ ☐ home ☐ cell

Would you like to receive CALL reminders to this #? yes / no
Would you like to receive TEXT reminders to this #? yes / no
Is it ok to leave treatment & financial messages at this #? yes / no

Social Security #: _____
Email: _____

Would you like to receive EMAIL reminders? yes / no
Is it ok to send treatment & financial messages to this email? yes / no

☐ single ☐ married ☐ divorced

Other Responsible Party

(another person you authorize to access patient info)

Relationship to Patient:
☐ mother ☐ father ☐ other_____
First Name: _____
Last Name: _____
Address: _____
City: _____State: ____ Zip:_____
Primary Phone: _____ ☐ home ☐ cell

Would you like to receive CALL reminders to this #? yes / no
Would you like to receive TEXT reminders to this #? yes / no
Is it ok to leave treatment & financial messages at this #? yes / no

Social Security #: _____
Email: _____

Would you like to receive EMAIL reminders? yes / no
Is it ok to send treatment & financial messages to this email? yes / no

☐ single ☐ married ☐ divorced

(continued on reverse side)

Patient Health Information

Medical Doctor's Name: _____

Medical Doctor's Phone: _____

YES	NO		YES	NO	
☐	☐	Pregnant	☐	☐	Injuries to face, jaw, mouth or teeth
☐	☐	Latex allergy (reaction to balloons, rubberbands, etc.)	☐	☐	Any speech problems/therapy
☐	☐	Other allergy _____	☐	☐	Grind or clench teeth
☐	☐	Current medications _____	☐	☐	Pain, tenderness or noise in jaw
☐	☐	Heart condition _____	☐	☐	Discomfort from teeth or gums
☐	☐	Frequent headaches	☐	☐	Are there any other dental/medical problems of which our doctors should be aware
☐	☐	Hepatitis			_____
☐	☐	HIV/AIDS			_____

Dental Insurance Information

Do you have insurance that covers orthodontic treatment? ☐ YES (complete below) ☐ NOT SURE (complete below) ☐ NO

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Company's Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Employer's Name: _____

Subscriber's Social Security #: _____ Subscriber's Birthdate: _____

Our office will send a claim to your insurance company on your behalf. The signer of the financial agreement with Wilson & Kim Orthodontics is responsible for the financial contract in its entirety. Any non-payment or claim denial from the insurance company is not the responsibility of Wilson & Kim Orthodontics.

Signature: _____ **Date**: _____

_____ ***(Initial)*** Cancellation policy: I understand I must give at least 1 (one) business day's notice to change or cancel my appointment in order to avoid being charged a $25 fee.

_____ ***(Initial)*** The information provided is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of changes to any information or the patient's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services that the patient may need. I understand that I am responsible for the payment of services rendered.

_____ ***(Initial)*** I authorize the release of dental/medical/insurance records to other dental/medical offices involved in the patient's continued orthodontic/dental treatment.

_____ ***(Initial)*** I acknowledge that I have received your NOTICE OF PRIVACY PRACTICES containing a complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its NOTICE OF PRIVACY PRACTICES, and that I may contact this organization at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Wilson & Kim orthodontics

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Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

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

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice: 1/1/2020
Privacy Official: Charis Santillie, (415) 878-0240, charis@WilsonKimOrthodontics.com