Orthodontic Team Member's Review of Practice Policies on Patient Privacy

Team Member's Name: _____

Team Member's Positions (check off all that apply):

☐TC ☐Bookkeeper ☐Receptionist ☐Insurance Secretary ☐DA ☐Records Tech ☐Lab Tech

Please acknowledge that you have done the following:

1. Read the "Notice of Privacy Practices" Pt. handout and understand how it applies to you. ☐Yes ☐No
2. Read the "Patient's Level of Privacy Consent" form and understand how it applies to you. ☐Yes ☐No
3. Attended a formal or on-line seminar (ADA, AAO, etc.) on HIPAA-based patient privacy. ☐Yes ☐No
4. Other training in HIPAA-related material _____

_____

_____

I acknowledge that the above is true and that I am sufficiently trained in Patient Privacy matters.

_____ _____

Team Member's Signature Date

File in Team Member's Personnel File