

HIPAA NOTICE OF PRIVACY PRACTICES

Vistancia Orthodontics

Effective Date: January 1, 2026

Practice Owner: Dr. Devin L. Croft DDS, MS, D'ACSD

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

Vistancia Orthodontics is committed to protecting the privacy of your health information. This Notice applies to all records of your care, including both **dental and medical services** provided at our practice. We are required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with this Notice of our legal duties and privacy practices.

ARIZONA-SPECIFIC PRIVACY & CONSENT PROVISIONS

In addition to federal HIPAA requirements, we comply with applicable **Arizona laws and AHCCCS (Arizona Health Care Cost Containment System) requirements**, including:

- **AHCCCS Members:** We will verify eligibility and may share necessary information with AHCCCS and its contractors for payment, care coordination, quality review, and program integrity purposes.
- **Minors (Under 18):** A parent or legal guardian generally has the right to access a minor's records and authorize treatment. However, Arizona law allows minors to consent to certain services (such as emergency care and, in limited cases, specific outpatient services). When a minor lawfully consents to their own care, we may limit parental access to related records as required by law.
- **Divorced/Separated Parents:** We will follow court orders and applicable Arizona law regarding access to a child's health information. Absent a court order to the contrary, either parent may have access.

- **Confidential Communications for Dependents:** Upon request, and when reasonable, we will accommodate alternative communication methods (e.g., separate billing address) to protect confidentiality.
 - **Substance Use Disorder Records:** If applicable, certain records may receive additional protections under federal and state law, requiring specific authorization before disclosure.
 - **Public Programs & Reporting:** We may disclose information to state agencies as required for public health reporting, abuse/neglect reporting, and other legally mandated programs.
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HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your health information for the following purposes:

- 1. Treatment** We may use your health information to provide, coordinate, or manage your care. This includes sharing information between dental and medical providers involved in your treatment. Including: Coordination between orthodontic and medical providers, reviewing your medical history prior to dental/medical procedures, and referrals to specialists.
- 2. Payment** We may use and disclose your information to bill and collect payment for services. Including: Submitting claims to dental and medical insurance, determining eligibility or coverage, and Billing statements and collections.
- 3. Healthcare Operations** We may use your information for practice operations. Including: Quality assessment and improvement, staff training, and business management and administrative activities.
- 4. Appointment Reminders & Communications** We may contact you via phone, text, email, or mail regarding appointments, treatment options, or health-related benefits.
- 5. Individuals Involved in Your Care** We may share relevant information with family members or others involved in your care unless you object.
- 6. Required by Law** We will disclose your information when required to do so by federal or Arizona law.
- 7. Public Health & Safety** We may disclose information for public health activities or to prevent serious threats to health or safety.

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8. Law Enforcement & Legal Proceedings We may disclose information in response to a court order, subpoena, or legal process.

9. Workers' Compensation We may disclose information as authorized by workers' compensation laws.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

We will obtain your written authorization for uses and disclosures not described in this Notice, including: marketing purposes, sale of your health information, certain uses of psychotherapy notes (if applicable), uses/disclosures restricted under Arizona law or AHCCCS rules when authorization is required. You may revoke your authorization at any time in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights:

- 1. Right to Inspect and Copy** You may request access to your medical and dental records.
 - 2. Right to Amend** You may request corrections to your records if you believe they are inaccurate or incomplete.
 - 3. Right to an Accounting of Disclosures** You may request a list of certain disclosures we have made.
 - 4. Right to Request Restrictions** You may request limits on how we use or disclose your information.
 - 5. Right to Confidential Communications** You may request we contact you in a specific way (e.g., only at work or by mail).
 - 6. Right to a Paper Copy** You may request a paper copy of this Notice at any time.
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OUR RESPONSIBILITIES

We are required to: Maintain the privacy and security of your health information, notify you in the event of a breach, and follow the terms of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. Updated versions will be available in our office and upon request.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with:

Vistancia Orthodontics or U.S. Department of Health & Human Services, Office for Civil Rights

You will not be penalized for filing a complaint.

CONTACT INFORMATION

Vistancia Orthodontics

Privacy Officer: Dr. Devin L. Croft DDS, MS, D'ACSD

Phone: 623-566-0800 Fax: 833-330-4585

Address: 9772 W Yearling Rd. Ste A1600, Peoria, AZ 85383

Email: drcroft@vistanciaortho.com

Website: www.vistanciaortho.com

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and/or been offered a copy of the Notice of Privacy Practices for Vistancia Orthodontics.

Patient Name: _____

Signature: _____

Date: _____

If signed by a personal representative:

Name: _____

Relationship to Patient: _____

OPTIONAL: COMMUNICATION PREFERENCES

Please indicate how you prefer to be contacted:

☐ Phone ☐ Text Message ☐ Email ☐ Mail

Preferred Contact Details: _____

OPTIONAL: AUTHORIZATION TO SHARE INFORMATION

I authorize Vistancia Orthodontics to share my health information with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____
