# Half Moon Dentistry

Dr. Tania McIntosh, General Dentist
15252 32 Ave #110 · Surrey, BC
Phone: 604-536-7697 · Email: info@halfmoondentistry.com · halfmoondentistry.com

## Patient Privacy Notice & Consent

*Personal Information Protection Act (PIPA) – British Columbia*

Half Moon Dentistry ("the Clinic," "we," "us," or "our"), led by Dr. Tania McIntosh, General Dentist, is committed to protecting the privacy and confidentiality of our patients' personal information. We provide dental care to patients of all ages. Where the patient is an adult, consent is given by the patient; where the patient is a child or is otherwise unable to consent, consent is given by a parent, guardian, or other person with authority to make decisions on the patient's behalf. This notice explains how we collect, use, disclose, and protect personal information in accordance with British Columbia's Personal Information Protection Act (PIPA) and the standards set by the BC College of Oral Health Professionals.

### 1. What Personal Information We Collect

To provide you with safe and effective dental care, we collect personal information that may include:

- Identifying information: name, date of birth, address, phone numbers, email
- Government identifiers: BC Personal Health Number (PHN), where required
- Insurance and billing information: dental plan details, policy and group numbers, payment information
- Health information: medical and dental history, medications, allergies, clinical findings, diagnoses, treatment plans, radiographs, photographs, lab results, and progress notes
- Where the patient is a child, information about the patient's parent(s), guardian(s), or substitute decision-maker; and emergency contact information for any patient
- Communications you have with the Clinic (appointment requests, messages, recorded calls where applicable)

### 2. Why We Collect and Use Your Information

We collect, use, and retain your personal information for purposes that a reasonable person would consider appropriate in the circumstances, including:

- Assessing your oral health and providing dental treatment
- Maintaining accurate clinical records as required by the BC College of Oral Health Professionals
- Consulting with specialists, laboratories, and other health-care providers involved in your care
- Processing insurance claims and direct billing
- Scheduling, confirming, and reminding you of appointments
- Sending recall and continuing-care notices
- Responding to inquiries, complaints, and requests
- Complying with legal, regulatory, and professional obligations (including reporting requirements)
- Internal quality assurance, risk management, training, and administration of the Clinic

### 3. How We Obtain Your Consent

Under PIPA, consent is required before we collect, use, or disclose personal information, except in limited circumstances permitted by law. An adult patient gives this consent for themselves; for a child patient (or a patient otherwise unable to consent), it is given by a parent, guardian, or substitute decision-maker.

**Implied consent.** When you (or your child) attend the Clinic for treatment, we rely on your implied consent to collect, use, and share personal information for the purposes of providing dental care within the "circle of care" (for example, sharing necessary information with specialists, dental labs, hygienists, assistants, the patient's physician, and other health-care providers directly involved in the patient's treatment).

**Express consent.** We will ask for your express consent for uses or disclosures that fall outside the direct provision of dental care — for example, appointment reminders or other communications by email or text, use of clinical photographs beyond the dental record, or release of records to a third party (such as a lawyer, a school, an insurer beyond direct claim submission, or a family member or separated parent who is not the requesting patient or guardian).

**Withdrawing consent.** You may withdraw your consent at any time, subject to legal or contractual restrictions and reasonable notice. Withdrawing consent for certain collections or uses may affect our ability to continue providing dental services. To withdraw consent, contact our Privacy Officer (see Section 8).

## 4. Who We May Share Your Information With

We may share your personal information with the following parties only as needed for the purposes described above:

- Dental specialists, physicians, and other health-care providers involved in your care
- Dental laboratories that fabricate your prostheses or appliances
- Your insurance provider, third-party benefits administrator, or government program (e.g., Pacific Blue Cross, the Canadian Dental Care Plan, the Healthy Kids program, ICBC, WorkSafeBC) for the purpose of billing and claims
- Service providers who support our operations (for example, our practice management software vendor, IT support, secure shredding services, accountants, and auditors), under written agreements that require them to protect your information
- Regulatory bodies, courts, or law enforcement, when required or authorized by law
- A successor organization if the Clinic is sold or transferred, in accordance with PIPA

Some service providers (for example, cloud-based software) may store or process data outside of Canada. Where this occurs, your information may be subject to the laws of that jurisdiction. We take reasonable steps to ensure comparable protection through contractual safeguards.

## 5. How We Protect Your Information

We use reasonable physical, technical, and administrative safeguards to protect your personal information against loss, theft, and unauthorized access, use, disclosure, copying, or modification. These include:

- Restricted access to charts and the practice management system on a need-to-know basis
- Confidentiality agreements with all staff and contractors
- Password protection, user-level access controls, and audit logging
- Encryption of electronic communications and backups where reasonable
- Locked storage of paper records and secure destruction of records that are no longer required

## 6. How Long We Keep Your Information

We retain dental records in accordance with the College's recordkeeping guidelines and applicable BC legislation. In general:

- Records for adult patients are retained for at least sixteen (16) years from the date of the last entry, or longer if required
- Records for patients who were children at the time of treatment are retained until at least sixteen (16) years after the patient reaches the age of majority (19 in BC)

- Financial records are retained as required under the Income Tax Act and other applicable laws

When records are no longer required, they are destroyed in a secure manner that protects confidentiality.

## 7. Your Rights

PIPA gives you the right to:

- Access the personal information we hold about you
- Request correction of personal information that is inaccurate or incomplete
- Request information about how we have used and disclosed your information
- Withdraw or vary your consent, subject to legal and contractual limits

To exercise any of these rights, please submit a written request to our Privacy Officer. We will respond within thirty (30) business days, as required by PIPA. A reasonable fee may apply for access requests, and we will provide an estimate in advance.

## 8. Privacy Officer

In accordance with PIPA, the Clinic has designated a Privacy Officer who is responsible for our compliance with this notice and with applicable privacy laws. Please direct any questions, concerns, requests, or complaints to:

**Privacy Officer:** Sarah Fox
**Clinic:** Half Moon Dentistry
**Mailing address:** 15252 32 Ave #110, Surrey, BC
**Phone:** 604-536-7697
**Email:** info@halfmoondentistry.com

If you are not satisfied with our response, you may contact the Office of the Information and Privacy Commissioner for British Columbia:

PO Box 9038 Stn Prov Govt, Victoria, BC V8W 9A4

Phone: 250-387-5629 · Toll-free in BC: 1-800-663-7867 · Website: www.oipc.bc.ca

# Patient Consent Form

*Please read, complete, and sign*

## Patient Information

| | | | |
|---|---|---|---|
| **Patient name** | | | **Date of birth** |
| **Address** | | | |
| **Home phone** | | **PHN** | |
| ***Complete the following only if the patient is under 19 (or otherwise unable to consent)*** | | | |
| **Parent / guardian name** | | | **Relationship to patient** |
| **Parent / guardian phone** | | **Parent / guardian email** | |

## A. Acknowledgement of Privacy Notice

☐ I have received, read, and understood the Patient Privacy Notice. I understand how Half Moon Dentistry collects, uses, discloses, retains, and protects personal information of the patient named above, and I understand the rights under the Personal Information Protection Act (BC).

## B. Consent to Collection and Use for Dental Care

☐ I consent to Half Moon Dentistry collecting, using, and disclosing the patient's personal information for the purpose of providing dental care, including sharing information as necessary with dental specialists, dental laboratories, the patient's physician, and other health-care providers directly involved in the patient's treatment.

☐ I consent to the submission of insurance claims and the disclosure of necessary information to the patient's dental benefits provider, government program, and any third-party administrator for the purpose of billing and claims processing.

## C. Optional Consents (please check each that applies)

*These items are not required to receive dental care. You may consent to some, all, or none of the following:*

☐ Appointment reminders by email

☐ Appointment reminders by text message (SMS)

☐ Appointment reminders by automated phone call

☐ Recall and continuing-care notices (e.g., reminders for cleanings, exams)

☐ Clinical photographs of the patient taken for inclusion in the dental record

☐ Newsletters or general dental health information by email

☐ Leaving voicemail messages at the phone number(s) provided above

*I understand I may withdraw any of these consents at any time by contacting the Privacy Officer.*

## D. Disclosure to Other Persons (optional)

I authorize Half Moon Dentistry to discuss the patient's dental treatment, account, and appointments with the following person(s) in addition to the patient or guardian signing below (for example, a spouse, the other parent, a grandparent, or a caregiver):

| Name | Relationship | Phone |
|---|---|---|
| | | |
| | | |

## E. Signature

By signing below, I confirm that I am the patient, or the parent / guardian / substitute decision-maker authorized to consent on behalf of the patient named above; that the information provided is accurate; and that I agree to the consents I have indicated above.

_____ _____

*Signature of patient, or parent / guardian / substitute decision-maker* | *Date (YYYY-MM-DD)*

_____ _____

*Printed name of signatory* | *e.g., self, mother, father, legal guardian*

## Office Use Only

| Received by (staff) | Date entered in chart | Patient chart # |
|---|---|---|
| | | |