Notice of Privacy Practices Acknowledgement

Effective September 1, 2013

I understand that, under the Health Insurance Portability Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and dental certifications.
- I understand that this information sent to myself, my other treating healthcare professionals and third-party payers via email or electronic submission may be sent unencrypted.

In addition:

- You have the right to request that we do not disclose treatment information for this service to a health/dental plan, if payment is made in full.
- You have a right to copies of your dental records.
- We are obligated to notify you in the event of a breach of unsecured protected health information.

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

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

OFFICE USE ONLY:
I attempted to obtain the patient's signature in acknowledgement on this NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as documented below: (if yes please list Date, Initials and Reason)

Signature:_____Date:_____

Patient Name (Please Print)_____