

# *Distinctive Dentistry*

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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 treatments 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 physician certifications.

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 anytime at the address above 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 when executing treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name (Please Print): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because:

- ◆ \_\_\_\_ Individual refused to sign
- ◆ \_\_\_\_ Communications barriers prohibited obtaining the acknowledgement
- ◆ \_\_\_\_ An emergency situation prevented us from obtaining acknowledgement
- ◆ \_\_\_\_ Other (Please Specify)

◆ \_\_\_\_\_