ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA'), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1)Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2)Obtain payment from third-party payers.
3)Conduct normal health care operation such as quality assessments and physician certifications.

I have received, read, and understood 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 it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time 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 to carry out treatment, payment, or health care operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name (print):_____
Relationship to patient: _____
Signature:_____Date: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient:_____Date of Birth:_____

*Written communications: Address to: _____
_____

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment.

*Oral communications: Call: (please fill in all that apply)
Home #_____
may we leave a message? Yes___ No ___
Work # _____
may we leave a message? Yes___ No ___
Cell # _____
may we leave a message? Yes___ No ___

*Oral communications: Call:
May we leave a message that you need pre-medication? Yes__ No__
May we leave a message you have a dental appointment? Yes__ No__
I do not want any reminder messages left at all _____(initials)
I do not want a postcard sent _____(initials)
(I understand that the office may charge me should I fail to keep my appointment)

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the *Notice of Privacy Practices* but was unable to do so as documented below.

Date_____Reason_____Initials_____ ____