Dr. Neumann and Dr. Dabbert

Serenity Dental

WEEPING WATER DENTAL

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding health information, under Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand this information can and will be used for:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from third-party payers for my health services
- Conduct normal health care operations such as quality assessments and improved activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and I may contact this office at the address below to obtain a 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 my treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you agree than you are bound to abide by such restrictions.

Patient Name _____ Date _____

Signature _____

Relationship to Patient _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy due to the following reasons:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

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