HEIDRICH & HEIDRICH

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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

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

I have been informed of my dental providers Notice of Privacy Practices containing a more complete description of the uses and disclosure 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 that I may contact this office 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 operations. Also, I understand that you (Dr's. Assistant) are not required to agree to my requested restrictions, but if you do agree, then you (Dr's. Assistant) are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature of Patient/Parent: _____

Relationship to patient: _____

List any dependent family members authorizing Dr's. dentist and staff to discuss any bill/treatments including fees and finances with the following person (s):

_____

_____

For Office Use Only: We are unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reasons: The patient refused to sign, communication barriers, emergency situation, other: