

**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 (HIPA A), I have certain right 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 direct 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 the 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.

**REQUEST FOR CONFIDENTIAL COMMUNICATIONS**

Patient Name (print) \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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 Home # \_\_\_\_\_ May we leave a message YES \_\_\_ NO \_\_\_

(please fill in all that apply) Work # \_\_\_\_\_ May we leave a message YES \_\_\_ NO \_\_\_

Cell # \_\_\_\_\_ May we leave a message YES \_\_\_ NO \_\_\_

Oral communications : May we leave a message that you need pre-medication ? YES \_\_\_ NO \_\_\_

May we leave a message you have a dental appointment ? YES \_\_\_ NO \_\_\_

May we mail you a reminder postcard for your appointment ? YES \_\_\_ NO \_\_\_

I understand that the office may charge me if I fail to keep my appointment \_\_\_\_\_ (initials)