SMILE
Wellness Co.

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

I have been informed of my healthcare provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosers of my protected health information. I have 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 the office to obtain a current copy of the *Notice of Privacy Practices* (important, the update 9-23-13 version reflecting the OMNIBUS rule).

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 healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patients Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Dependent family member also covered by this acknowledgment:

_____

Additional Disclosure Authority:

OTHER-SPECIFY

_____

_____

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We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason: □ The patient refused to sign □ Communication barriers □ Emergency Situation □ Other _____

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