ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability&Accountability Act of 1996 (HIPPA), 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 operations such as quality assessments and physician certifications.

I have received, read and understand 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 its *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 that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

Patient Name (print) _____

Relationship to Patient _____

Signature _____Date_____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name_____ Date of Birth _____

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

Home # _____may we leave a message?   Y   N
Work #_____may we leave a message?   Y   N
Cell#_____may we leave a message?   Y   N
Email _____may we send a message?   Y   N

May we send an appointment reminder text message?   Y   N
May we leave a message that you need pre-medication?   Y   N
May we leave a message that you have a dental appointment?   Y   N
I do not want a reminder 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*oral communication

FOR 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 document below.

Date_____ Reason_____Initials____