Print Email

Bella
dental care

Acknowledgement of Privacy Practices

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

- **Provide and coordinate may treatment among a number of Health care 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 opreations such as quality assessment and improvement activities**

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses 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 that I may contact to office at the address below to obtain the current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict now my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do then 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 Practices due to the following reasons.

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