

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my 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 healthcare provider who may be involved in that treatment directly and indirectly.
- 2). Obtain payment from third-party payers.
- 3). Conduct normal healthcare operation 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 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 current copy of the **Notice of Private 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 restrictions, but you do agree then you are bound to abide by such restrictions.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____ Date of Birth: _____

I request that all communication to me by and / or his staff be handled in the following manner:

Written communication: 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 communication: Call Home # _____

May we leave a message? Yes ____ No ____

Work # _____

May we leave a message? Yes ____ No ____

Cell # _____

May we leave a message? Yes ____ No ____

Oral communication: call We may leave message that you need pre-medication? Yes ____ No ____

We may leave message that you need dental appointment? Yes__ No__

I attempted to obtain the patient's signature in acknowledge on this Notice of Privacy Practices acknowledge, but was unable to do so as documented below.

Date:

Initials:

Reason:

