Bellevue
Dental Care
& Implant Center
Family, Cosmetic & Implant Dentistry

ACKNOWLEDGEMENT 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 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 operations 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 and 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 this office 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 our treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ Date: _____

Signature:_____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement.

Additional Disclosure Authority:

OTHER_____your signature
OTHER _____their name/ your signature
Other-Specify_____name/ your signature

For Office Use Only:

We were unable to obtain patient's written acknowledgement of our Notice of Practices due to the following reason:

- Patient refused to sign
- Communication barriers
- Emergency situation
- Other