ACKNOWLEDGEMENT OF PRIVACY PRACTICES
HAYES COSMETIC & FAMILY DENTISTRY

3224 George Washington Hwy
Hayes, VA 23072

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 (HIPAA). I understand that this information can and will be used to:

1. **Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly**
2. **Obtain payment from third-party payers for my health care services**
3. **Conduct normal health care operations such as quality assessment and improvement activities**
4. **Contact you by mail or phone to remind you of appointment or treatment**

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 at the address above 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 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 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:
_____
_____
_____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

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