PRIVACY PRACTICES of Hoekwater Family Dentistry

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
-conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
-obtain payment from third-party payer

I have received a copy of this office's Notice of Privacy Practices. I understand that I may receive appointment confirmation messages (as well as reminders about pre-medicating prior to an appointment) via answering machine, voicemail, postcard, email, text message or through another member of the household.

Print Name:____

Signature:____
(parent or guardian if patient is under age 18)
Date:____

You may discuss my dental health and financial information with:

Name:___________________________Relationship to Patient:________________

Name:___________________________Relationship to Patient:________________

Name:___________________________Relationship to Patient:________________

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement

Date: Staff name: Reason: