NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Smart Family Dental Care
Dr. Orson Baek, D.D.S.,P.C.
3780 Holcomb Bridge Rd. Ste A
Norcross, Georgia 30092

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 and indirectly
*Obtain payment from third-party payers
*Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received 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 its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time 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. I also 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.

I understand that Orson Baek, D.D.S., P.C. will be happy to duplicate and make available at my request any x-rays that have been taken for the purpose of diagnosis. Orson Baek, D.D.S., P.C. will retain all original x-rays and only provide duplicates. I agree to pay the duplication fee of $50.00 for these x-rays.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

Office Use Only

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

Date_____Initials_____Reason_____