Patient Name: _____ DOB: _____

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 (HIPAA), I have certain 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 health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from the third party payers.
3. Conduct normal health care operations 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 its *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 operation. I also under that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

(Below to be filled out by parent or legal guardian if patient is under the age of 18)

Parent/Legal Guardian (please print): _____Relationship to Patient_____

Signature_____ Date_____

Please provide names of whom you give consent to Wheaton Cosmetic Dentistry to provide information regarding your account:

Name: _____ Relationship: _____
Name: _____ Relationship _____
Name: _____ Relationship _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

May we leave a message on **HOME** number? **Yes_____No_____**
May we leave a message on **MOBILE** number? **Yes_____No_____**
May we leave a message on **WORK** number? **Yes_____No_____**
May we send an **EMAIL**? **Yes_____No_____**

May we send an appointment reminder text message? **Yes_____No_____**
May we leave a message that you need pre-medication? **Yes_____No_____**
May we leave a message that you have a dental appointment? **Yes_____No_____**

I do **NOT** want a reminder left at all_____(initials)
I do **NOT** want a postcard sent_____(initials)

I understand that the office may charge me should I fail to keep my appointment (see Financial Policy)

FOR OFFICE USE ONLY

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

Date_____Reason_____Initials_____