Acknowledgement of Privacy Practices

Saxon Dental
870-39 Saxon Blvd.
Orange City, Fl 32763
(386) 775-1001

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 dental care services
- ❑ Conduct normal health care operations such as quality assessment and improvement activities.

I have been given an opportunity to attain a copy of my dental providers *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. 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 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.

Please list any person or persons you are allowing us to discuss your privacy information with (such as appointments, treatment, and billing)

_____
_____

Patient name: _____

Signature: _____

Relationship to Patient (if minor/legal guardian): _____

Date: _____

For office use only:

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

❑ The patient refused to sign	❑ Emergency Situation
❑ Communication barriers	❑ Other