



# CARTER | SLEDGE

Family Dentistry

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES contains a more complete description of the uses and disclosures of my health information. I understand that Dr. Carter has the right to change his NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used and 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 agree then you are bound to abide by such restrictions.

PATIENT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### OFFICE USE ONLY:

I have attempted to obtain the patient's signature in acknowledgement on the NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as documented below:

DATE: \_\_\_\_\_ INITIALS: \_\_\_\_\_

REASON: \_\_\_\_\_