Acknowledgement of Privacy Practices

Premier Dental Clinic
3825 Martin Way E #101
Olympia, WA 98506
360-456-7628

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 (HIPAA). 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 health care services
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* 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 our treatment, payment 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.

Patient Name: _____ Chart #: _____

Signature: _____ Date: _____

Relationship to Patient : _____

Dependent family members also covered in this acknowledgment:

_____

_____

For office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due the following reason:

- ❑ The patient refused to sign
- ❑ Communication Barriers
- ❑ Emergency Situation
- ❑ Other