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 ('HIPPA'), I have certain rights to privacy regarding my 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 healthcare provider who may be involved in that treatment directly and indirectly.
2) Obtain payment from third-party payers.
3) Conduct normal healthcare operation 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 it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain current copy of the *Notice of Private 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 understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________ Date: ____________

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: ______________________________ Date of Birth ____________

I request that all communication to me by ____________ and/or his staff be handled in the following manner:

***Written communications: Address to: ______________________________**

____

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

*Oral communication: Call: Home # ______________________________

May we leave a message? Yes ___ No ___

Work # ______________________________

May we leave a message? Yes ___ No ___

Cell # ______________________________

May we leave a message? Yes ___ No ___

* Oral communication: Call: We may leave message that you need pre-medication? Yes ___ No ___

We may leave message that you have dental appointment? Yes ___ No ___

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: