Acknowledgement of privacy practices

Ronald L. Schoepflin, DDS, PS
6500 SE Mile Hill Drive
Port Orchard, WA 98366

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 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 *Notices 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 operations and I understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Permission to talk about my treatment & costs with: _____
Circle what applies: Spouse/Partner/Children/Parent(s)/Friend or Family Member

Dependent family members (under 18y/o) also covered by this acknowledgement: _____

_____

For Office Use Only:
We were unable to obtain patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other_____