ACKNOWLEDGEMENT OF PRIVACY PRACTICES

FALL CITY FAMILY DENTAL

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33609 Redmond-Fall City Road Fall City, WA 98024
(425) 222-7011

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 out 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: ______________________________________ **Date:** _____________________

Signature: ____

Relationship to Patient: ____

Dependent family members also covered by this acknowledgement:

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For Office Use Only:

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

_____ The patient refused to sign
_____ Communication barriers
_____ Emergency situation
_____ Other

Staff Signature_____________________________ **Date**__________________