

LEADING EDGE DENTAL CENTER, LTD.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations 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 its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the office address 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. I also understand 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: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of this Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home telephone number _____

O.K. to leave a message with detailed information

Leave a message with call-back number only

Work or alternate (cell) number _____

O.K. to leave a message with detailed information

Leave a message with call-back number only

I authorize the following persons to be contacted regarding my PHI

PLEASE NOTE: A scheduled appointment is a commitment of time between the Doctor and the patient. Therefore we make every effort to help you to keep these commitments.

As a courtesy to our patients we confirm all scheduled appointments one to two days prior to the appointment. This is why we ask that the above form be as complete as possible to allow us to contact you appropriately.

If you find that you are ever unable to keep a scheduled appointment, a 24-48 hour notice will allow us to schedule another patient in need of treatment and to find a more suitable time for you. A minimal charge of **\$50.00** may be placed on your account for any broken appointment.

Patient signature: _____ Date: _____