Patient Acknowledgment of Receipt

The Facts About Fillings

Dental Materials Fact Sheet

☑ I acknowledge that I have received from G. Allen Herrera, D.D.S., Concord Dental Care, the Dental Materials Fact Sheet developed by the Dental Board of California.

☑ I understand that this fact sheet has been provided to me in an effort to ensure I am fully informed of the variety of materials available for dental restorations.

☑ I understand that I should review this information to make a fully informed decision regarding dental restorative treatment.

☑ I also understand that if I have questions or concerns regarding this information that it is my right to have a discussion regarding this aspect of my care with my dentist before undertaking any restorative treatment.

_____

Patient / Guardian Name

_____ _____

Patient / Guardian Signature *Date*

Patient Acknowledgment of Receipt
Notice of Privacy Practices

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 practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at ant time 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 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 / Guardian Name

_____ _____

Patient / Guardian Signature *Date*

OFFICE USE ONLY

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

Date: ____/____/____ Initials: _____ Reason: ☐ Patient refused to sign ☐ communication barrier ☐ Emergency situation ☐ other _____