<u>ACKNOWLEDGEMENT OF PRIVACY PRACTICES</u>

Regina A Boling DDS, PC
5332 A Hwy 115
Clarkesville, GA 30523

My signature confirms that I have been informed of my rights to privacy regarding any 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 issued 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: _______________________

°°

For Office Use Only:

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

__The patient refused to sign
__Communication barriers
__Emergency situation
__Other:____