

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT  
AND CONSENT FOR TREATMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), 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 or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices. 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 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 do agree then you are bound to abide by such restrictions. I understand that from the physical design of the office that I may overhear personal information and I will not discuss with anyone.

I also consent for Dr. Wallingford or a staff member to take x-rays, study models, photographs, or any other diagnostic aid deemed appropriate by Dr. Wallingford to make a thorough diagnosis of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risk.

**Patient Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_