Milos M. Boskovic, DDS
Full Spectrum, State of the Art Tooth Replacement

Ivanka Srbinovska, DDS
Personal Comprehensive Adult Dentistry

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:______________________

You have the right to refuse to sign this Acknowledgement

I, ____, have
(Signature of Patient)

received a copy of this office's *NOTICE OF PRIVACY PRACTICES*

as required by federal law.

____
(Print Patient's Name)

____
(Patient's Signature)

FOR OFFICE USE ONLY

On the date above we made a "good faith effort" to obtain written acknowledgement of receipt of our *NOTICE OF PRIVACY PRACTICES*. We were unable to obtain acknowledgement for the following reason:

☐ Patient refused to sign

☐ Other____
(Possible reasons: Language difficulty, communication barriers, dental emergency)

____________________ ________________________________
(Printed Name) (Signature of employee attempting to gain acknowledgement)

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PATIENT CONSENT FORM

Patient's Name:____

Address:______________________________ City______________________

CA, Zip__________ Phone: ( )____________________ Fax: ( )______________

Privacy Officer (PO):____________________ Office Contact Person (OCP):______________

- Posted in our lobby is our *NOTICE OF PRIVACY PRACTICES*. It provides information about how our office may use and disclose your Protected Health Information (PHI);

  You have the right to review our *Notice of Privacy Practices* before signing this *Patient Consent Form.* Please take the time to do so now. A copy is attached.

  You have the right to request that we restrict how your PHI is used or disclosed for Treatment, Billing/Payment, or Dental Office Operations. *Request for Restriction of PHI* must be submitted to the OCP in writing and signed by you as specified in our *Notice*;

  - Our office does not have to agree with your *Request for Restriction of PHI.* If we agree to your *Request for Restriction of PHI*, we shall honor that agreement.

  You have the right to revoke this *Patient Consent Form. Revocation of Consent* must be submitted to the OCP in writing and signed by you as specified in our *Notice*;

  - A *Revocation of Consent*, does not affect disclosures made prior to the date the *Revocation* was made.

- Our *Notice of Privacy Practices* may change from time-to-time. If it does, you will receive a "revised" *Notice* on the first visit after changes to the *Notice* were made.

- **Your signature below** signifies your consent to the use and disclosure of your PHI by our office during Treatment, Billing/Payment, and Dental Office Operations as outlined in our *Notice.*

- Our office may condition dental treatment upon execution of this *Patient Consent Form.*

- This Form is provided to you so that our office may comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Patient Consent was signed by:______________________________ ____________________
(Print Name of Patient or Representative) (Relationship to Patient)

____ ____________________
Patient's Signature Date

Witnessed by:______________________________ ____________________
(Print Name of Privacy Officer or Office Contact Person) (Title)

____ ____________________
Signature Date