CARTER | SLEDGE
Family Dentistry

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 heath care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal heath care operations such as quality assessments and physician certifications.

I have received, red and understand your NOTICE OF PRIVACY PRACTICES contains a more complete description of the uses and disclosures of my heath information. I understand that Dr. Carter has the right to change his NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used and 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 agree then you are bound to abide by such restrictions.

PATIENT NAME: _____

SIGNATURE:_____ DATE:_____

OFFICE USE ONLY:

I have attempted to obtain the patient's signature in acknowledgement on the NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as documented below:

DATE: _____ INITIALS: _____

REASON:_____

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