# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 operation 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 organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private 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.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

**OFFICE USE ONLY**

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

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorized the dental staff to perform the necessary dental services I may need.

**I UNDERSATND THAT PAYMENT AND/OR MY ESTIMATED PORTION IN WHOLE IS DUE AT THE TIME OF SERVICE AND IF THIS INCLUDES MULITPLE VISITS PAYMENT WILL BE MADE AT THE INITIAL VISIT.** OTHER RESTRICITIONS AND/OR POLICIES MAY APPLY. SEE OFFICE POLICIES. Of office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Signature _____ Date _____

My method of payment will be _____

I certify that I am covered by insurance as indicated on my information supplied to my dental provider. I assign directly to Neil Dental Group all insurance benefits, otherwise payable to me. I understand that I am responsible for all charges and payment of services rendered and also responsible for paying any co-payment and deductible or charges that are not paid by my insurance company. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on my insurance submissions, whether manual or electronic. I authorize Neil Dental to take every step willing and/or capable of collecting the insurance portion.

Signature _____ Date _____