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 operations such as quality assessments and physician certifications

I acknowledge that I have obtained Stoner Periodontics & Implant Specialists (the “**Practice**”) *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that the Practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the Practice at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that the Practice restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the Practice is not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

By initialing the following, I am giving the Practice the authority to speak with those individuals indicated below whom I have authorized regarding my treatment and the financials for my treatment. I am also acknowledging that I have received a copy of the Practice’s *Notice of Privacy Practices*.

\_\_\_\_ Right to correspond with family member(s) as listed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: \_\_\_\_\_\_\_\_\_

\_\_\_\_ Right to correspond with all doctor’s office involved with treatment

\_\_\_\_ I also understand that all types of communication are not secure. Knowing this, I authorize SP & IS to communicate with me via:

Cell Phone: \_\_\_\_\_\_\_ Text: \_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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** |
|  |  |  |