

Central Texas Pediatric Dentistry, PA

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Privacy Policy
Acknowledgement

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received this office's Notice of Privacy Practices. Specifically, I understand that my protected health information will be used to:

- Conduct, plan and direct my (or my child's) treatment and follow-up among other healthcare providers who may be involved in that treatment
- Obtain payment (e.g. insurance companies, collection agencies, check processing companies)
- Conduct normal healthcare operations such as quality assessment

I also understand that the usual business practice of this office is to use an open bay for most treatment, to text/email at your request, and to call to confirm appointments one day prior to most appointments. Please check the appropriate boxes below if you **do not** want any of our business services listed below:

- Do not use an open bay for patient treatment. Schedule all appointments for the VIP room. I understand that this may limit my ability to schedule appointments as there is only one private treatment room in this office.
- Do not text or email to confirm appointments. I understand that missing appointments may result in dismissal from the office.
- Do not call to confirm appointments. I understand that missing appointments may result in dismissal from the office.

Patient Name: _____

Your Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's (or parent's) signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented.

- Patient or parent was given notice, but forgot to sign before leaving the office.
- Patient or parent refused to sign.
- Notice was mailed to patient or parent.

Staff member: _____ Date: _____