Our Family Caring for Yours
sabrina e. mickel DDS
and Associates

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICE
Sabrina E. Mickel, DDS & Associates Inc.

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has a right to change the *Notice of Privacy Practices* and I may contact this office at the address above to obtain a current copy of the Notice of Privacy 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PRINT NAME _____ DATE _____

SIGNATURE _____

RELATIONSHIP TO PATIENT _____

DEPENDENT FAMILY MEMBERS ALSO COVERED BY THIS ACKNOWLEDGEMENT:

_____

FOR OFFICE USE ONLY:

WE WERE UNABLE TO OBTAIN THE PATIENT's WRITTEN ACKNOWLEDGEMENT OF OUR NOTICE OF PRVACY PRACTICES DUE TO THE FOLLOWING REASON:

- o THE PATIENT REFUSED TO SIGN
- o COMMUNICATION BARRIER
- o EMERGENCY SITUATION
- o OTHER _____