

CENTRE FAMILY DENTISTRY

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) 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 certification

I give Dr. Geraets and staff permission to discuss any issues pertaining to my dental needs, including treatment and billing issues, with _____.

I, _____, have received a copy of this office's Notice of Privacy Practices.

Printed Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)
