Acknowledgement of Receipt of Notice of Privacy Practices

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 have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that Adam T. Fox, DMD has the right to change is *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

Patient Name: _____ _____
(Please Print) (Relationship to Patient)

Signature: _____ _____
(Please Sign) (Date)

Do we have your permission to:

Leave a message on your answering machine	☐ Yes ☐ No
Confirm appointments	☐ Yes ☐ No
Remind you of any pre-medication (if Applicable)	☐ Yes ☐ No
Speak to household members concerning your dental care	☐ Yes ☐ No
Send a text Message regarding future appointments	☐ Yes ☐ No
Send an E-mail regarding future appointments	☐ Yes ☐ No

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

FOR OFFICE USE ONLY

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

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other: _____
(Please specify)

V1.00

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