Wallace Family Dental

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 have received, read, and understand your NOTICE OF PRIVACY PRACTICES contains a more complete description of the uses and disclosures of my heath information. I understand that Dr. Wallace has the right to change his NOTICE OF PRIVACY PRACTICES.

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

Patient Name: _____

Signature: _____ Date: _____

Office Use Only:
I have attempted to obtain the patient’s signature in acknowledgement on the NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

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