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Dino Kid's
DENTISTRY

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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

-Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly

-Obtain payment from third-party payers for my healthcare services

-Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Statement 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 *Statement of Privacy Practices*. I understand that my dental provider has the right to change the *Statement of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Statement 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 healthcare 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.

Patient Name: ____ DOB: _______________________

Parent/Guardian Name: ____

Signature: ____Date: _______________________

Dependent and family members also covered by this acknowledgement:

*Dino Kid's Dentistry has a cancellation policy that requires **48 hour** notifications prior to scheduled appointments for changes, cancellations, and no-shows. This $50 charge will apply to every appointment scheduled.

For office use only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practiced due to the following reason:

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