ACKNOWLEDGEMENT OF PRIVACY PRACTICES

CHARDONNAY DENTAL
250 CHARDONNAY AVE
PROSSER, WA 99350

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 (HIPAA). 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 that treatment directly and indirectly
- ❑ Obtain payment from third-party payers for my health care services
- ❑ Conduct normal health care operations such as quality assessment and improvement activities

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 the right to change the *Notice of Privacy Practices* and that 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.

Patient Name: ___________________________________ Date: __________________________

Signature: ______________________________________

Relationship to Patient: ___________________________

Dependent family members also covered by this acknowledgement:______________________________

For Office Use Only:

I have attempted to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other

Date: ______________________________ Initials: ______________________________

Please document the reasons you were unable to obtain the signature.

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RECONOCIMIENTO NOTIFICACIÓN DE PRÁCTICAS DE PRIVACIDAD

He recibido una copia de las Prácticas de Privacidad de Chardonnay Dental y Entiendo que Chardonnay Dental tiene el derecho a cambiar las Prácticas de Privacidad de tiempo a tiempo y que yo puedo comunicarme con Chardonnay Dental en cualquier momento para obtener una copia de la Notificación más reciente de las Prácticas Privadas.

Nombre del Paciente ____

Firma del paciente/ ____

Representante Legal

Relacion al Paciente ____

Fecha____________________________

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- ☐ The patient refused to sign
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Date: _______________________________ Initials: _______________________________

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