**Notice of Privacy Practice Acknowledgement**

**Privacy Policy**

**Acknowledgement**

**V12.08.09**

I have received this office’s Notice of Privacy Practices. Specifically I understand that my protected health information will be used to:

* Conduct, plan and direct my (or my child’s) treatment and follow-up among other healthcare providers who may be involved in that treatment
* Obtain payment (e.g. insurance companies, collection agencies, check processing companies)
* Conduct normal healthcare operations such as quality assessment

I also understand that the usual business practice of this office is to use an open bay for most treatment, to text/email at your request, and to call to confirm appointments one day prior to most appointments. Please check the appropriate boxes below if you **do not** want any of our business services listed below:

* Do not use an open bay for patient treatment. Schedule all appointments for the VIP room. I understand that this may limit my ability to schedule appointments as there is only one private treatment room in this office.
* Do not text or email to confirm appointments. I understand that missing appointments may result in dismissal from the office.
* Do not call to confirm appointments. I understand that missing appointments may result in dismissal from the office.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Office Use Only**

I attempted to obtain the patient’s (or parent’s) signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented.

* Patient or parent was given notice, but forgot to sign before leaving the office.
* Patient or parent refused to sign.
* Notice was mailed to patient or parent.

Staff Member: Date: