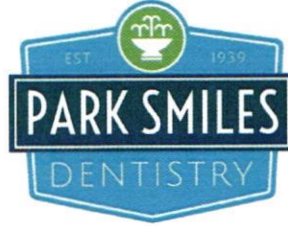
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT



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 the treatment directly and indirectly.
- Obtain payment from a third party payer
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time 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 healthcare operations. I also understand 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 ____

Signature ____________________________________ Date ___________

I authorize Park Smiles Dentistry to discuss/release information to the following individuals:

Name of individual ____

Relationship to Patient ____

OFFICE USE ONLY

I Attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date________ Initials_______ Reason ______________________________

Park Smiles Dentistry
1566 W Fairbanks Avenue
Winter Park, Fl 32789
(407) 645-4645

Name ______________________________ Social Security # ______________________________

Residential Address ______________________________ Date of Birth ______________________

City ______________________ Zip __________ Home/Cell Phone ______________________

Email Address ____

Employer ______________________________ Business Phone ______________________

Business Address ________________________ City __________________ ZIP ______________

Occupation ____

Marital Status _____ Single _____ Married ______ Divorced ______ Widow/ Widower

Whom may we thank for referring you? ____

Previous Dentist ____

Person Responsible for the account if other than patient ______________________________
IF SO, the best contact number would be ______________________________________

Do you have dental Insurance? _______Yes ______ No
IF Yes please continue below, otherwise sign and date at the bottom

Name of Dental Insurance ____

Address to file claims ____

Insurance phone Number ________________________________ Group Number______________

Name of Subscriber ____________________________________ Date of Birth________________

Social Security of Subscriber____

Name of Employer (which insurance is through)____

We will be happy to file primary insurance claims as a courtesy to our patients provided we can verify eligibility and benefits from your insurance provider. Patient is responsible for any balance not covered by insurance.
Payment is due when services are rendered. Other financial arrangements must be made in advanced. Visa/Mastercard/ Discover are accepted. Appointment time is exclusively for you. A charge may be made for an appointment that is broken without 24 hour notice.

I authorize release of information relating to insurance claims. I authorize payment directly to Park Smiles Dentistry, benefits otherwise payable to me. I affirm that the information given is true and accurate.

X____ Date ______________________________