Notice of Privacy Practices Acknowledgement

Please read, sign and date this acknowledgement and bring it with you to your appointment.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarded by protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment, and follow-up, among the multiple healthcare providers who may be involved in treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received, or read, your HIPAA containing a more complete description of the uses and disclosures of my information. I understand Grand Dental has the right to change its HIPAA from time to time and that I may contact them at any time to obtain a current copy. I understand that I may request, in writing, that you restrict how my private information is used to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by those restrictions.

Signature: _____ Date: _____