Advanced Dental Artistry
Restorative & Esthetic Dentistry

118 SW 330th, Suite 103
Federal Way, WA 98023
(253) 835-2296

Acknowledgement of Privacy Practices

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 (HIPPA). 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 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 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 by this acknowledgement:

_____

_____

_____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

[] The patient refused to sign
[] Communication barriers
[] Emergency situation
[] Other