SEATTLE
SPECIAL CARE DENTISTRY™

ACKNOWLEDGEMENT OF PRIVACY POLICY

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 other 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 had the right to change the *Notice of Privacy Practices* and that I may contact this office at the address below 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 requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Dependent family members also covered by this acknowledgement: _____

PATIENT COMMUNICATION PREFERENCES

Method	Phone # / Email address	Yes	No	Specific Instructions- (Circle one)
Home Phone				OK to leave detailed message? Y / N
Work Phone				OK to leave detailed message? Y / N
Cell Phone				OK to leave detailed message? Y / N
Text				
Email				Encrypted / Un-encrypted **

**Please note: sending sensitive information via encrypted email ensures that the content will be read only by the intended recipient. In order to read your encrypted message, you may be required to enter a password or key, and/or register for an account with the email encryption service.

From the above, list your preferred method of communication for the following:

a. Confirmation of appointments: _____

b. All other communication: _____

Other than you, your insurance carrier, and/or health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

Name: **Contact Info:**

□ Spouse _____

□ Parent _____

□ Other Relative (indicate relationship to patient) _____

□ Other-specify _____

(IE: Caretaker, Group Home, Trust Administrator, Legal Guardian, POA)

By initialing here _____, I hereby give permission to leave medical information pertaining to me, or my dependent, at the number(s)/ email(s) listed above. I also assume responsibility to inform the practice of changes in my contact information and/or preferences, and/or to revoke specific medical information authorization at any time.

For Office Use Only:

We were unable 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