4600-D Pinecrest Office Park Drive | Alexandria, Virginia 22312
Office: 703-642-6425 | Fax: 703-642-2257

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 & Accountability Act of 1996 (HIPAA).*** 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 assessments and improvement activities.

I have been informed of my dental provider's ***Notice of Privacy Practices*** containing 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 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 that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

____

Please Print Patient's (Last Name) (First Name) (Middle Initial)

____

(Signature of Patient/Parent or Legal Guardian) (Date)

Emergency Contact Name: ____________________ Emergency Contact Phone:___________________

Do we have your permission to:
Send an appointment reminder to your home? Yes______ No______

Leave appointment, billing or dental information with the person named below:

Name/Names: ____