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Smile Dental Care PC

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT
(Health Insurance & Accountability Act of 1996)

Smile Dental Care P.C. takes your oral health very seriously.
To help us meet all your healthcare needs, please fill out this form completely.

PATIENT ACKNOWLEDGEMENT

Patient Name (Last, First, M.I.) : _____

_____

Thank you for taking the time to review our Notice of Privacy Practice. If you have any questions, we want to hear from you. If you do not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this acknowledgement to our office at the address indicated above.

_____ _____
Patient/Guardian Signature Date

You reserve the right to request your information not to be release to: _____
For Example: Do not bill my insurance. Do not release my information to my spouse

Please check one:

- ☐ Please provide me with a copy
- ☐ I do not require a copy

Smile Dental Care, P.C.
HIPPA Privacy Officer

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An Emergency Situation prevented us from obtaining the acknowledgement
- ☐ Other (specify) _____