Notice of Privacy Practices Acknowledgment

PATIENT INFORMATION:

Name: _____

Home Phone Number:_____ Cell Phone Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Email Address:_____

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

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

I have received, read and understand Kakaris Family Dentistry's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that I may request, in writing, that Kakaris Family Dentistryrestrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Kakaris Family Dentistry is not required to agree to my requested restrictions, but if Kakaris Family Dentistry does agree then Kakaris Family Dentistry is bound to abide by such restrictions.

PERMISSION TO DISCUSS DENTAL TREATMENT

In the event that you may want a family member or friend to discuss your dental treatment with Kakaris Family Dentistry, we must have in writing permission/consent from you to do so. Please list any person you give Kakaris Family Dentistry permission/consent to discuss your dental treatment. PLEASE NOTE: If the patient is a minor, we will discuss dental treatment with either a parent or guardian.**

Name of family members or friends that we can discuss your dental treatment with:

Name: _____ Phone Number:_____

Name: _____ Phone Number:_____

Name: _____ Phone Number:_____

Please select one of the following regarding our communication about your dental treatment:

( ) I hereby give permission/consent to Kakaris Family Dentistry to discuss any and all dental treatment with the above named individuals.

( ) I do not wish Kakaris Family Dentistry to discuss ANY of my dental treatment with anyone other than me.

_____ _____

Patient Signature Date

_____ _____

**Parent or Guardian Signature (if the patient is a minor) Date