Dr. Raffi
GENERAL & IMPLANT DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

1) Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider who may be involved in that treatment directly and indirectly.
2) Obtain payment from third-party payers.
3) Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information us used or disclosed to carry out treatment, payment, or health care operation. I also understand you are not required to agree to my request restriction, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____Date: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____Date of Birth _____

I request that all communication to me by _____ and/or his staff be handled in the following manner:

*** Written communications: Address to: _____**

If the address provided above is not your home address **or** not a street address, please provide us with a street address for purposes of ensuring payment:

*Oral communication: Call: Home # _____
May we leave a message? Yes_____ No_____

Work # _____
May we leave a message? Yes _____ No_____

Cell # _____
May we leave a message? Yes _____ No _____

* Oral communication Call: We may leave a message that you need to pre-medication? Yes _____ No_____

We may leave message that you have dental appointment? Yes _____
No_____

OFFICE USE ONLY

Attempted to obtain the patient's signature in acknowledgement on *this Notice of Privacy Practices* acknowledgement, but was unable to do so as documented below.

Initials: Reason: