<u>Vaughn Endodontics</u>

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ACKNOWLEDGEMENT

NOTICE OF PRIVACY PRACTICE (HIPAA)

***** You May Refuse To Sign This Acknowledgement *****

Summary

We may use or disclose your Protected Health Information to provide treatment and/or services in order to manage and coordinate your dental care. For example, we may share your medical/dental information with other health care providers, laboratories, etc. to ensure that the medical/dental provider has the necessary information to diagnose and provide treatment to you. We will use the information you provide to obtain payment for your dental services from your insurance. The information you provide will be used to manage, operate and support the business activities of our practice. This office fully complies with all standards of the HIPAA (Health Insurance Portability and Accountability Act) to ensure your health information is protected. For more details regarding HIPAA please see the additional information provided with this document.

Please Print Patient Name ➔ ______________________________ is aware and understands HIPAA Privacy Act as summarized above and fully provided with this form.

Please Indicate Spouse, Relative, Friend etc. ➔ _______________________________ has authorization from patient named above to inquire, obtain, or discuss patient's care and financial responsibility with this office.

____ ___________________________________

Patient's Signature Date

This office attempted to obtain written acknowledgement of receiving our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused sign
___ Communication barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (specify)