Illiana Endodontics, Inc.

Michael J. Mintz, D.D.S., F.I.C.D.

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 (HIPAA), I have certain 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 health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your *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.*

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 health care operation. 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.

Patient Name (print) ______________________________

Relationship to Patient ______________________________

Signature______________________________Date ______________

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name______________________________Date of Birth ______________

Address ______________________________

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

Home # ______________________ may we leave a message? Yes______ No______

Work # ______________________ may we leave a message? Yes______ No______

Cell # ______________________ may we leave a message? Yes______ No______

Email ______________________ may we send an email? Yes______ No______

May we send an appointment reminder text message? Yes______ No______

May we leave a message that you need pre-medication? Yes______ No______

May we leave a message that you have a dental appointment? Yes______ No______

I do not want a reminder left at all ______________ (initials)

I do not want a postcard sent ______________ (initials)

I understand that the office may charge me should I fail to keep my appointment * oral communications

FOR OFFICE USE ONLY

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

Date________________Reason______________________________Initials __________