Acknowledgement of Privacy Practices

Susan L. Sockwell, DMD, PC
104 Ansley Dr.
Dahlonega, GA 30533

My signature confirms that I have been informed of my rights to privacy regarding my protected dental information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers, including the staff of Dr. Sockwell, who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers for my dental care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I authorize the staff of Susan L. Sockwell, DMD to:

- leave messages on my answering machine or in my voicemail regarding my account or appointments
- send continuing care postcards to my home address
- communicate my financial account, medical record and appointment schedule with (Name)_____, (Relationship)_____ either in person or on the telephone should I not be available to do so.

Patient Name: _____ Chart #:_____

Signature: _____ Date:_____

Relationship to Patient (if minor): _____

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For Office Use Only

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency Situation
- ☐ Other: _____

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