ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Children’s Dental Care
24837 104th Ave SE #200
Kent, WA  98030
253-850-1234

Children’s Dental Care
18008 State Route 410 E Suite B
Bonney Lake, WA  98391
253-826-5000

My signature confirms that I have been informed of my rights to privacy regarding my protected health 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 who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health 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 addresses above to obtain a current copy of the 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 operations and I understand that you are not required to agree to me requested restrictions, but if you agree then you are bound abide by such restrictions.

Patient Name: ________________________________________  Date: ______________________

Signature: ___________________________________________

Relationship to Patient: ________________________________

For Office Use Only:

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

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other