NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

GOLD HILL FAMILY DENTISTRY
PO BOX 1088
492 SECOND AVE.
GOLD HILL, OR 97525

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ACKNOWLEDGMENT AND CONSENT

I understand that Gold Hill Family Dentistry / Casey D. Clingan, DMD will use and disclose **health information** about me.

I understand that my **health/dental information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health/dental status, symptoms, examination, test results, diagnoses, treatment, procedures, prescriptions, and similar types of health/dental - related information.

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 and agree that this practice (Gold Hill Family Dentistry / Casey D. Clingan) may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health/dental care providers for my care and treatment;
- Determine my eligibility for dental plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my dental care; and
- Perform various office, administrative and business functions that support my dentist's efforts to provide me with, arrange and be reimbursed for quality, cost-effective dental care.
- Appointment Reminders - We may call or write to remind you of scheduled appointments or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post car, and/or leave you a reminder message on your home answering machine, cell phone or with someone who answers your phone if you are not home.

I also understand that I have the right to receive and review a written description of how this practice (Gold Hill Family Dentistry / Casey D. Clingan DMD) will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices follow by the employees, staff and other office personnel of this practice, and my right regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of the practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that this practice is not required by law to agree to such requests.

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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

By Signing below, I agree that I have received and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient Name:

Relationship to Patient:

Date:

Signature:

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OFFICE USE ONLY

I 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:

Date: Initials: Reason: