Notice of Privacy Practices Acknowledgement

Dr. Carl E. Baccellieri Jr., DMD
Dr. J. Neil Della Croce, DMD, MS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the health care providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third- party payers.
*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 organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address 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. 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.

Patient Name: _____

Relatioship to Patient: _____

Signature: _____

Date: _____

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Dr. Carl E. Baccellieri Jr., DMD
Dr. J. Neil Della Croce, DMD, MS

I give permission to the office of Dr. Carl E. Baccellieri Jr., DMD. and Associates,

* to leave reminders of appointments and any medication instructions with the following people or on my answering machine. Y ☐ N ☐

* I realize that I can modify this list at any time by notifying this office in writing. Y ☐ N ☐

Please check ALL or ANY that apply:

( ) 1. _____ _____
Spouse Phone #

( ) 2. _____ _____
Parent Phone#

( ) 3. _____ _____
Child Phone #

( ) 4. _____ _____
Signifiant Other Phone #

( ) 5. _____ _____
Other & relationship to the patient Phone#

Signature: _____ Date: _____

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date: _____ Initials: _____ Reason _____