Baccellieri Family Dentistry

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and 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 as well as follow-up among healthcare providers involved in my treatment.
- Obtain payment from dental insurances and third-party payors.

I understand that I can ask for a current copy of "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information.

I understand that I can request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment. I also understand that you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by them.

I give permission to Baccellieri Family Dentistry to leave reminders of appointments on my voicemail

Yes _____ No _____

I give permission to Baccellieri Family Dentistry to leave messages with the following people:

1._____ _____ _____

Name Relationship Phone #

2. _____ _____ _____

Name Relationship Phone #

Patient Name: _____

Patient (or Responsible Party) Signature: _____

Date: _____