Acknowledgement of Privacy Practices
A Smile Shoppe
521 E. Elder St. #203
Fallbrook, CA 92028
(760) 728-1592

My signature confirms that I have been informed of my rights to privacy regarding my protected health information (PHI), under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). 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

Under the Health Information Technology for Economic and Clinical Health Act (HITECH) and HIPPA Omnibus rule of 2013:

- You may be notified if any breach of your health or financial data occurs.
- Your authorization is required for the disclosure of PHI for fundraising, marketing, research, or educational purposes.
- Your authorization is required before the sale of any PHI
- You have the right to request that health plans not be notified of services that are paid in full by you.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses of disclosures of my PHI. 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 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 my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that A Smile Shoppe will use e-mail correspondence for appointment reminders, overdue statements, delivering digital radiographs, among other uses pertaining to my dental care. I realize that I can opt out by not giving my e-mail address to A Smile Shoppe, or by asking to have it removed from our system. I understand that A Smile Shoppe will use standard e-mail services and will not use it to send me junk mail. If I request radiographs or dental record information for myself or for a specialist, it will be send by standard email unless I request a more secure method. In this case, I will provide a disk or flash drive for the data transfer.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

Authorization to Release Information

I understand that no one other than myself and **those listed below** are able to access information or authorize treatment on my behalf:

_____ _____

Patient acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____, acknowledge that I have received, or have been offered, from A Smile Shoppe a copy of the Dental Materials Fact Sheet dated October 2001, as required by law.