Cleona Dental, LLC

Dr. Jennifer Davis

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I understand that this information can be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or 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 understand my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address listed above to obtain a current copy.

I certify that I have received a copy of this office's Notice of Privacy Practices.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Practices but acknowledgement could not be obtained because:

___ Individual Refused to Sign ___ Communication Barrier ___ Emergency Situation

___ Other (please specify)

I authorize information to be released to :
For example: spouse, parent, caregiver.

I understand and acknowledge my rights as detailed in the Notice of Privacy Practices Presented here.

I understand and consent to my medical information being used as described here.

I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned here.

What is the best phone number to reach you?

May we leave a message? If yes, please note any restrictions.

YES

NO

Who may we contact in case of emergency?

Name:

Phone number:

Name:

Signature:
(patient, parent or guardian)

Date: