James Merlo, DDS
Anthony Hirschenberger, DDS, FAGD
9301 Calumet Ave., Suite 2A
Munster, IN 46321

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

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 that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal health care operation such as quality assessments and physician certifications.

I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this 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 operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name (print) _____

Relationship to Patient (if patient is a minor) _____

Signature _____ Date _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient _____ Date of Birth _____

Written Communications: **Address to:** _____

_____

E-mail address: _____

May we leave an E-mail message? Yes _____ No _____

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment.

Oral Communications: Call: **Home #** _____
(Please fill in all that apply)
May we leave a message? Yes _____ No _____

Work # _____
May we leave a message? Yes _____ No _____

Cell # _____
May we leave a message? Yes _____ No _____

May we leave a message that you need pre-medication? Yes _____ No _____
May we leave a message that you have a dental appointment? Yes _____ No _____
I do not want any reminder messages left at all _____(Initials)
I do not want a postcard sent _____(Initials)
(I understand that the office my charge me should I fail to keep my appointment)

Signature _____ Date _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the *Notice of Privacy Practices* but was unable to do so as documented below:

Date:_____ Reason:_____ Initials: _____