THE SMILE CENTER OF ROCKLAND
NOTICE OF PRIVACY PRACTICED
ACKNOWLEDGEMENT AND CONSENT

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 the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up with the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain reimbursement for services: confirm coverage, billing or collection activities, and utilization review.
- Conduct normal healthcare operations that include the business aspects of running a practice; including quality assessment and improvement activities, auditing functions, and customer service.

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 **The Smile Center of Rockland** has the right to change its' **Notice of Privacy Practices** from time to time and that I may contact them at any time to request a current copy of Privacy Practices.

I understand that I may request in writing how my private information is used or disclosed to carry out treatment, payment or health care operations.

Patient Name (Please Print):_____

Signature:_____Date:_____

Signature of Patient Representative:_____

Relationship to Patient Representative:_____

Office Use Only

I have attempted to obtain the patient's signature, but was unable to do so as documented below.

Date:_____Initials_____Reason:_____

_____

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