Today's Date_____

HIPAA Acknowledgment Notice of Privacy Practices

Print Name of Patient _____
Patient Date of Birth _____

We, at Massie Dental, are required by law to maintain the privacy of and provide individuals with access to the notice of our legal duties and privacy practices with respect to protected health information. I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document and understand that I may obtain a copy for my records upon request.

Signature of Patient/Legal Representative_____

Please let us know which number you would like us to call regarding your medical information. Note that this is the number where we will leave a message if we do not reach you.

□ Home phone □ Cell phone □ Both

Name/Signature of Witness: _____

NOTICE TO PATIENTS

We would like to make our patients aware of the changes in the health insurance industry. Many of the major insurance companies have underwritten other insurance companies and plans. Sometimes it's not clear cut from policy to policy what they will cover or will not cover. Please know that whatever type of insurance you have our office will continue to file it as a courtesy to you. However, your insurance is strictly a contract between you and them. Ultimately, any charges that are not paid by your insurance are your responsibility. We greatly encourage you to call your insurance company before receiving any type of dental treatment to make sure that the service and the provider are covered by your insurance plan.

I have read and understand above information. _____

Patient Signature Date

_____

Patient printed name