VIVIAN H. BAE D.D.S.
20710 1ST AVE S.
DES MOINES, WA. 98198

ACKNOWLEDGEMENT 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 & Accountability Act" (HIPPA) of 1996.
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 or indirectly.
- Obtain payment from-third party payers (insurance companies for example) for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have the right to be 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 have 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.

I understand that I may request in writing that my dental provider restrict how my private information is used or disclosed to carry out treatment, payment or health care operations, and I understand that my dental provider is not required to agree to my requested restrictions, but if said provider does agree, then he/she is bound to abide by such restrictions.

Patient name: _____ Date: _____

Signature: _____

Relationship to patient if not signed by patient: _____

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For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ other