Better and Gentle Family Dentistry
150 Hurley Avenue
Kingston, NY 12401
845.339.0964
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H.I.P.P.A. Acknowledgement

Patient Information		
First Name:	Last Name:	MI:

H.I.P.P.A. Acknowledgement

I understand that, under the Health Insurance Portability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information, I understand that this information an and will be used to:

- 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
- Obtain payment from third party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I acknowledge that I have received 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 operations. I also understand you are not required to agree to my request restrictions, but if you do agree you are bound to abide by such restrictions.

Signature:		Date:
Print First Name:	Print Last Name:	Relationship to Patient: ☐ Self ☐ Child ☐ Guardian

For Office Use Only

I attempted to obtain the patients signature in acknowledgement on the **Notice of Privacy Practices Acknowledgement,** but was unable to do so as documented below:	
Signature:	Date:
Print First Name:	Print Last Name:

Thank you for your business!