BACCELLIERI FAMILY DENTISTRY

630 Cope Road, Suite A Kennett Square, PA 19348 (610)444-0208 / Fax: (610)444-0653

Notice of Privacy Practices Acknowledgement

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

*Conduct, plan and direct my treatment and follow-up among the 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 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 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 requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____
Relationship to Patient: _____
Signature: _____
Date: _____

BACCELLIERI FAMILY DENTISTRY

630 COPE ROAD, SUITE A
KENNETT SQUARE , PA 19348
(610) 444-0209
(610) 444-0653

Notice of Privacy Practices Acknowledgement

I give permission to the office of Dr. Carl E. Baccellieri Jr., DMD and Associates,

- To leave reminders of appointments and any medication instructions with the following people or on my answering machine. Y_____ N_____
- I realize that I can modify this list at any time by notifying this office in writing. Y_____ N_____

Please check ALL or ANY that apply:

( ) 1. _____ _____
Spouse Phone #

( ) 2. _____ _____
Parent Phone #

( ) 3. _____ _____
Child Phone #

( )4. _____ _____
Significant Other Phone #

( )5. _____ _____
Other & relationship to patient Phone #

Signature: _____ Date: _____

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

_____