LAUREL
FAMILY · DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____ understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent,

I authorize you to use and disclose my protected heath information to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), obtaining payment from third party payers (i.e. my insurance company) and for the day to day healthcare operation of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to theses requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Printed Name	Signature	Relationship to Patient	Date

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL RESPONSIBILITY

I certify that I, and/or my dependent(s) have Insurance coverage with _____(name of insurance company), and assign directly to Rubicon Dental Associates all insurance benefits (if any). I understand that I am financially responsible for all charges whether or not they are paid by insurance.

If any collection is necessary, I, the financially responsible undersigned adult person, agree to pay all pre and post judgment collection costs including attorney's fees. I authorize the use of my signature on all insurance submission.

Rubicon dental Associates may use my health care information and may disclose such information to the above name Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Printed Name	Signature	Relationship to Patient	Date

Office Use Only

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES, BUT ACKNOWLEDGMENT COULD NOT BE OBTAINED BECAUSE:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgment

____ Other (Please specify) _____