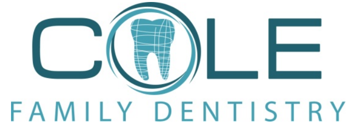

JEFFREY A. COLE, D.M.D. SUSAN G. COLE, D.M.D. DIANA E. SHOE, D.D.S.

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that information supplied by me or my representatives can and will only be used to:

- Conduct, plan and direct my dental treatment and for follow-up among multiple health care providers that may be involved in my treatment either directly or in-directly.
- Obtain payment or information from my dental insurance company. This includes verifying benefits and claim status.
- Call any number provided by patient to confirm appointments. This will also include mailing, emailing, or texting reminders for my next recall appointment.
- Conduct normal business operations.

I have received, read and understand your Notice of Privacy Practices containing a more detailed explanation of the uses and disclosures of my protected health information. I understand that COLE FAMILY DENTISTRY, L.L.C. has the right to change its Notice of Privacy Practices from time to time, and that I am entitled to receive a copy at any time by calling their office at 717-632-2565.

I also understand that I may request in writing that COLE FAMILY DENTISTRY, L.L.C. restrict how my protected health information is used or disclosed to carry out my dental treatment, obtain payment or health care operations. I understand that COLE FAMILY DENTISTRY, L.L.C. is not required to agree to my request. However, if they do, they are required by law to abide by my restrictions.

By signing below, I acknowledge receipt of the Notice of Privacy Practices and give my consent to use my protected health information supplied to this office in the way listed above. I understand that any other disclosures besides what is listed above require a signed authorization presented by this office.

Do you authorize us to leave detailed messages at your home and/or on your voicemail? ☐ **Yes** ☐ **No**

With whom do you authorize us to speak concerning treatment? : ____

Their relationship to you, the patient? : ____________________________

I have reviewed, understand and agree to the content of the notice of privacy.

Patient Name: ____

Signature of Patient or Guardian: ____

Date: ______________________________________

There is no expiration of this form unless otherwise noted by the patient.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement to the Notice of Privacy Practices notice, but was unable to do so as stated below.

Date: ______________________ Initials: __________ Reason: ______________________________