Notice of Privacy Practices Acknowledgement
Drs. Greiner, Visger Dental Associates, Inc.
7553 S. Center Street
Mentor, Ohio 44060
(440) 255-2600

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 multiple health-care providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician Certification.

I acknowledge that a copy of **Notice of Privacy Practices is** available to me upon request 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 requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ___________________________

Relationship to Patient: ___________________

Signature: _______________________________

Date: ________________

Office Use Only

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

Date: __________ Initials _________ Reason _______________________________________

Drs. Greiner, Visger Dental Associates, Inc.

Who may we talk to about your medical concerns? ______________________________

Is this contact for emergency puroses only? Yes ____ No ____

If above answer is "no", may we communicate on your behalf? Yes ____ No ____

May we release information to your physicians for continuity of care? Yes ____ No ____

May we leave a message at your home with other residents? Yes ____ No____

On your answering machine/voicemail/email? Yes____ No____

Email address____

May we contact you at work? Yes____ No____

<u>IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INDIVIDUAL INSURANCE PLAN, NOT THE DENTAL OFFICE.</u>

Dear Patient,

Due to the many ongoing changes in the dental insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay up to date and aware of these changes, it is not always possible to do so.

Therefore, we find no other alternative but to strongly urge you, as the covered patient, to please call your insurance company, prior to any treatment, and become familiar with what your plan does and does not cover. **<u>It is your responsibility to know your own individual plan, not the dental office.</u>** Failure to comply with the suggestion could result in you, the patient, being responsible to pay for the entire amount of the charges incurred.

Please remember that knowing and understanding your insurance policy is crucial and that it is between you and your insurance company and not between the doctor and the insurance company.

SIGNATURE: ____

DATE: ____