



Pallotto Dental Care

Personalized & Comfortable

Patient Acknowledgement and Consent of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected information about you and how you can get access to this information, in compliance with the Health Insurance Portability and Accountability Act of 1996/2013.

By signing this form, you understand that our use and disclosure of protected health information about you, including in electronic form, can be used to:

1. Conduct, plan and direct treatment and follow up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Protected health information may be disclosed or used for treatment and billing for your services.
4. Communicate with insurance carriers. We will not sell or use your information for marketing or fundraising.
5. Conduct normal healthcare operation such as quality assessments and physician certificates.
6. The patient has the right to request changes to the consent in writing at any time.
7. The patient has the right of confidential communication. You can provide us with specific instruction on how to contact you. Messages will be left at phone numbers provided.
8. You have received a copy of our Notice of Privacy Practices.

I, _____ have received a copy of this office's **Notice of Privacy Practices**.

_____ Date _____

Signature of Patient/Parent/or Legal Guardian

Please specify relationship to patient (*If signed by other than patient*) _____

If you would like to give us permission to discuss your care with any other person than yourself/patient, please list below.

| | |
|--------------------------------|--|
| Name: | Relationship: |
| Name: | Relationship: |
| Patient Name: | |
| Signature: | <input type="checkbox"/> Patient <input type="checkbox"/> Guardian |
| Print name (Person who signed) | Date: |