THE TOOTH SHOP OF OCALA, LLC
1226 SE 24th ROAD ◆ OCALA, FL 34471 ◆ (352) 732-2458

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

Initial Each Box

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

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers (such as insurance companies) if applicable.
- Conduct normal healthcare operations.

☐ I understand that I may request a copy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at any time to obtain a current copy of the Notices of Privacy Practices.

☐ I understand that I may request in writing that THE TOOTH SHOP OF OCALA, LLC restrict how my private health information is used or disclosed to carry out treatment, payment, or health care operations. I also understand THE TOOTH SHOP OF OCALA, LLC is not required to agree to my requested restrictions, but if THE TOOTH SHOP OF OCALA, LLC does agree then the practice is bound to abide by them.

☐ For Patients who bring companions to their appointments: I understand that my private health information may be discussed at any time during interactions between myself and the staff. If I allow my companions to be present during such interactions, my companions may be exposed to my private health information. It is my responsibility to exclude my companions from such conversations between myself and the staff, if I do not wish my companions to be exposed to my private health information.

☐ I authorize THE TOOTH SHOP OF OCALA, LLC staff to leave messages and/or emails pertaining to my appointments and I assume responsibility to notify them whenever this information has changed. (The staff will not leave messages containing private medical or dental information)

I authorize access to my Protected Health Information for the following persons (*optional*):

Name (print):_____ **Relationship:**_____

Name (print):_____ **Relationship:**_____

I understand my rights as listed above. I authorize THE TOOTH SHOP OF OCALA, LLC to leave messages at the phone numbers l provided and share Protected Health Information for the above persons.

Patient (print):_____ **Signature:**_____ **Date:**_____

**********_____***Office Use Only***_____**********

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

Date:_____ **Staff Member:**_____ **Reason:**_____