keller orthodontics
CUSTOM • CRAFTED • SMILES

Notice of Privacy Practices Acknowledgment

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

- *Conduct, plan and direct my treatment and follow up among multiple healthcare 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 customer service.*

I have received, read and understand your Notice of Privacy Practices 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 to obtain a current copy of the Notice of Privacy Practices.

Patient Name (Print): _____

Relationship to Patient: _____

Signature: _____

Date: _____

For Office Use Only

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

Date: Initials: Reason: