NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Ashely E. Burns, D.D.S.
4214 Andrews Hwy.
Suite 300
Midland, Texas 79703
Phone (432)697-3333 Fax (432)697-0240

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information has been provided to me in the Notice of Privacy Practices. 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 (insurance companies).

Conduct normal healthcare operation and quality assessments.

Conduct appointment reminding activities such as voicemail or answering machine messages, messages left with secretaries or family members, postcards or letters.

Discuss treatment with a parent, spouse, family member, or any one responsible for paying my account.

I have received 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 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 information is used or disclosed to carry out treatment, payment or health care operations.

I understand that I do not have to sign this Acknowledgement.

Print Patient Name: ____________________

Relationship to patient: ____________________

Signature: ____________________

Date: ____________________

OFFICE USE ONLY

I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

It was emergency treatment. ____
I could not communicate with the patient. ____
The patient refused to sign. ____
The patient was unable to sign. ____

Other (please describe). ____________________

____________________ ____________________
Staff Signature Date