NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT
PATIENT CONSENT FORM

HUGH HERRINGTON DDS
1426 WEST COLLEGE STREET
PULASKI, TN 38478
931-363-6300

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 that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers whom 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 certifications.**

I have received, read, and understand, your Notice of Privacy Practices containing a more complete description of there 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 Private 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.

Due to HIPPA (Health Insurance Privacy & Accountability Act) Regulations, mention above, we must ask you the following questions regarding you PHI (Protected Health Information).

DOES OUR OFFICE HAVE PERMISSON TO?

- **Leave a message on your answering machine at home? YES NO**
- **Contact you by cell phone (text messaging or phone call)? YES NO**
- **Discuss your medical condition or dental treatment such as Appointment time, Pre-medications or other prescriptions with any member of your household? YES NO**
- **If yes, whom: _____Relationship_____**
- **Leave message or try to contact you at your place of employment? YES NO**

Patient Name_____

If Patient is a minor, 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:_____