ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Eyad Shehadeh, D.D.S., P.A.
973 North Nob Hill Road
Plantation, Florida 33324

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the health insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a member of health care providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 private information is used to disclosed to carry our treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Patient Signature: _____

Relationship to Patient: _____

For official use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practice due to the fallowing reason:

( ) The patient refused to sign

( ) Communication barriers

( ) Emergency situation

( ) Other