NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT

By my signature below, I acknowledge that I have read and understand the Notice of Privacy Practices of Dr. Chandur Wadhwani, Dr. Alfonso Piñeyro, and the staff of Northwest Prosthodontics. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that 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.
- Photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Additionally:

- May we send you postcards regarding appointments that you have or appointment that are needed? _____ NO _____ YES
- May we leave messages regarding your health information on your answering machine or voice mail at home? _____ NO _____ YES
- Are there any members of your family, household, or those coming with you to this appointment with which we should **not** discuss any of your health care issues?
  _____ NO _____ YES (If yes, please list below)
  _____

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:

- ❑ The patient refused to sign
- ❑ Communication barriers
- ❑ Emergency situation
- ❑ **Other _____**