Acknowledgement of Privacy Practices
For
Dave Wagner D.D.S.

My signature confirms that I've been informed of my right to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). 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 or indirectly.
- My signature authorizes payment of insurance benefits to be paid to Dr. David Wagner DDS and any payment arrangement made via phone, email or in the office.
- Conduct normal health care operations such as quality assessment and improvement activities.

I've 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 a copy of such Notice of Privacy Practices. I understand that my dental provider has 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 or disclosed to carry out treatment, payment or health care operations and I understand that you're 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:_____

Signature:_____

Relationship to
Patient:_____

Dependent family members covered by this acknowledgment: