

# STATEMENT OF PRIVACY PRACTICES

**Livingston Pediatric Dental Associates**

**315 East Northfield Road**

**Livingston, NJ 07039**

**973.992.5555**

## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for Livingston Pediatric Dental Associates. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of the office's health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Livingston Pediatric Dental Associates reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

**I authorize contact from this office to confirm my child(ren) appointment, treatment and billing information via:**

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above              |

**I authorize information about my child(ren) be conveyed via:**

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above              |

**I approve being contacted about special services, events, fund raising efforts or new health information on behalf of this Healthcare Facility via:**

- |  |  |
|--|--|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above            |
| <input type="checkbox"/> Text Message  | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email         |  |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

You may refuse to sign this acknowledgement and authorization, in refusing we may not be allowed to process your insurance claim. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

### Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (PLEASE SPECIFY)	YES	NO

Name of Patient \_\_\_\_\_

Signature of Patient or Representative \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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### OFFICE USE ONLY BELOW THIS LINE

#### Record of Acknowledgement Not Obtained

Provided Prior to Treatment

YES NO

Date Provided:

#### Reason For Denial:

- Needed more time to review Statement of Privacy Practices
- Individual refused to sign
- Communications barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Wanted to consult with another person before signing
- Reason not given
- Other (Explain):

Copy of signed authorization provided to the individual:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_