smiles on madison

family & cosmetic dentistry

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I acknowledge that I have been offered a copy of the Statement of Privacy Practices for the office of Smiles on Madison. The Statement of Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for service, or in the performance of office 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.

Smiles on Madison reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If 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.

Patient Name: _____

Date: _____

Signature: _____

Relationship to patient: _____

Dependent family members also covered by this acknowledgement: _____

_____

FOR OFFICE USE ONLY:

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

____ The patient refused to sign
____ Patient unable to sign
____ Communication barriers
____ Emergency situation
____ Other: Explain _____