

# Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

- \* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- \* Obtain payment from third-party payers.
- \* Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below 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. I also understand you are not required to agree to my requested restrictions. If we deny your request, we will provide you a written explanation.

## Questions and Complaints:

If you have any questions about this notice, please contact:

### Taylor Dental Associates, Inc

William S. Cabaniss, D.D.S.  
Mark E. Falke, D.D.S.

Carolyn Haverland  
Practice Administrator

920 North Main St  
Taylor, TX 76574  
Telephone: 352-5577  
Fax: 352-7416

## Acknowledgement Form:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

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

Signature \_\_\_\_\_

Date \_\_\_\_\_

### For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reasons.

- \_\_\_ Patient refused to sign
- \_\_\_ Communication barriers prohibited obtaining the acknowledgement
- \_\_\_ An emergency situation prevented us from obtaining acknowledgement
- \_\_\_ Other (Describe ) \_\_\_\_\_