Patient Acknowledgement of Receipt of Privacy Practices & Consent Form

Sergeant Bluff Dental, PLLC

703 1st Street

Sergeant Bluff, Iowa 51054

I have received a copy of this office's Notice of Privacy Practices.

I understand that under the Health Insurance and 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, but in not mandatory for me to sign in order to:

- Conduct, plan and direct my treatment and follow up among multiple health care providers who may be involved in that treatment directly and indirectly
- The process to obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy/completely read a copy of your Notices 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 above 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, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying this consent.

Patient Signature or Patient Representative Date

Waiver of Liability

Your insurance will only pay for services that are covered in your plan provisions. This is an agreement between you and your insurance company. Your policy may deny payment for any services.

I have been informed that my insurance may deny payment for services rendered. If my insurance denies payment, or only pays a portion of the charge, I agree to be personally and fully responsible for the payment in full.

Patient Signature or Patient Representative Date

A COPY OF THIS CONSENT WILL BE IN YOUR PATIENT CHART. YOU ARE ENTITLED TO A PAPER COPY BY REQUEST.