ROBERT T. CORTE D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ___________________________(Print Name), have received a copy of this office's Notice of Privacy Practices.

_____________________________ _______________
{Signature} {Date}

We want you to know our policies and procedures which were developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

In order to continue to provide the following services we will need your consent for the release of select health information. We will use your health information for administrative and clinical office procedures designed to optimize scheduling and coordination of care between staff and dentist. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel **providing you treatment**. We may include your health information with an invoice used to collect payment for treatment you receive in our office. This will be sent as a family statement to the responsible party on record. We will send health information with insurance forms filed for you in the mail or electronically. We may discuss with your insurance company or their representatives your health information. Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on care and inform you of treatment options or services. These communications may include postcards, letters, telephone reminders or electronic reminders. If you are unavailable we may leave a message with a family member or on an answering machine/voice mail.

_____________________________ _______________
{Signature} {Date}

For Insurance Patients

I authorize release of any information relating to my dental claims. I understand that I am responsible for all costs of dental treatment. I also authorize payment directly to Dr. Corte of the group insurance benefits otherwise payable to me.

_____________________________ _______________
{Signature} {Date}