Quality Dental Center, Inc.
COMMITED TO YOUR SMILE
Top Dental Practice In D.C.

5437 Connecticut Ave., N.W. Suite # 203
Washington, D.C. 20015

NOTICE OF PRIVACY PRACTICES

My signature confirms that I have been informed of my privacy reguarding my protected health information, under the Health Insurance Portability and Accounting Act 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental providers Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office 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 and I understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

_____ _____
Patient Name Date

_____
Signature

Relationship to patient: _____

For Office Use Only:

We were unable to obtain the patients written acknowledgement of our Notice of Practices due to the following reason:

- **Patient refused to sign**
- **Emergency situation**
- **Communication Barrier**
- **Other : _____**