

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Evolution Dental Care
9134 W Silver Spring Drive
Milwaukee, WI 53225

Acknowledgement	
<p>I, _____, hereby acknowledge that I have received and reviewed a copy of Evolution Dental Care's <i>HIPAA Notice of Privacy Practices</i>.</p> <p>I understand that Evolution Dental Care's <i>HIPAA Notice of Privacy Practices</i> may change periodically and that I am entitled to receive a copy of Evolution Dental Care's revised <i>HIPAA Notice of Privacy Practices</i> upon request.</p> <p>I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Evolution Dental Care will not refuse treatment to me if I refuse to sign this Acknowledgement.</p>	
Patient Signature	Date
Signature of Personal Representative	Print Name of Personal Representative
	Relationship of Personal Representative to Patient

Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance).

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature _____ Date _____

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section)

FOR OFFICE USE ONLY		
Evolution Dental Care made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its <i>HIPAA Notice of Privacy Practices</i> . In spite of these efforts, Evolution Dental Care was unable to obtain a signed Acknowledgement for the following reason(s):		
<input type="checkbox"/> Refusal to sign Acknowledgement on _____, 20_____.		
<input type="checkbox"/> Communications barriers prohibited us from obtaining a signed Acknowledgement.		
<input type="checkbox"/> An emergency situation prohibited us from obtaining a signed Acknowledgement.		
<input type="checkbox"/> Other (Describe): _____		
Date Received	By	Patient ID