NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT
&
PATIENT CONSENT FORM

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

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 assessments and physician certifications.

I have received, read and understand 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 take into consideration such **Notice of Privacy Practices**, as it applies to me or my child, prior to signing this consent. I understand that this organization (Crossroads Family Dental) is not required to agree to my requested restrictions but if this organization (Crossroads Family Dental) does agree, then they 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 this Organization has already taken action relying on this consent.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

Crossroads Family Dental
1314 Eagle Ridge Drive
Schererville, IN 46375

OFFICE USE ONLY

We attempted to obtain the patient's signature in acknowledgement on this **Notice of Privacy Practices Acknowledgement & Patient Consent Form,** but were unable to do so as documented below.

Date: Initials: Reason: