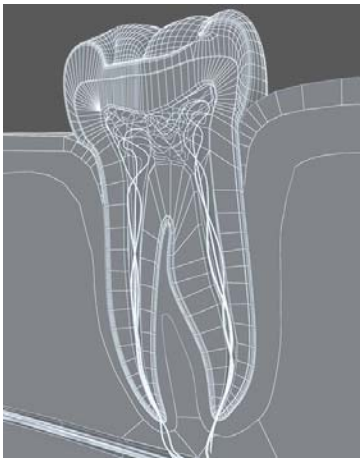

PRECISION ENDODONTICS, PC

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance 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 to:

1. Conduction, plan and direct my treatment and follow-up among multiple health care providers who may be involved in that treatment directly and/or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care 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 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 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 operation. I also 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: _____ Relationship to Patient: _____

Signature (Guardian, if patient is under 18): _____ Date:_____

Request for Confidential Communication

Oral communications should be directed to:

Home Number:_____ May we leave a message? Yes____ No____

Work Number: _____ May we leave a message? Yes____ No____

Cell Number: _____ May we leave a message? Yes____ No ____

Electronic communications should be directed to:

E-Mail: _____

** Please note that we use a reminder system that communicates through e-mail and text messaging.*

May we leave a message to remind you to pre-medicate before your appointment? Yes_ No

May we leave a message to remind you of your dental appointment? Yes___ No___

I understand that the office will charge me a $25.00 fee if I fail my appointment or cancel within 24 hours of the appointment time.

Signature (Guardian, if patient is under 18): _____ Date: _____