COWLITZ RIVER DENTAL

Dr. Lily B. Crocco, DMD ~ Dr Samuel D. Crocco, DMD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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:

- 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 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PERMISSION TO DISCUSS DENTAL TREATMENT

_____ **Publication Of Records**: I authorize photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and insurance reimbursement purposes. My identity will not be revealed to the general public without my permission.

In the event that you may want a family member or friend to discuss your dental treatment with our office, we *must* have in writing permission/consent from you to do so. Please list any person you give Cowlitz River Dental permission/consent to discuss your dental treatment and/or financial arrangements for your treatment.

*****Please initial the appropriate space below to give or withhold consent and sign and date the bottom portion of this form.

NAME: _____ CONTACT INFO: _____

NAME: _____ CONTACT INFO: _____

___I hereby **give** permission/consent to Cowlitz River Dental to discuss any and all dental treatment with the above-named individuals.

___I **do not** wish Cowlitz River Dental to discuss any of my dental treatments with anyone other than me.

CANCELLATION POLICY

Please provide at least 24 hours notice prior to your scheduled appointment to avoid a $75 missed appointment fee. You can Call or Text (360)274-9100, Leave a message or e-mail (crdincr@gmail.com) to inform us as soon as possible. Any notice is appreciated and will be considered.

Signature: _____ Date: _____