Perkiomen Valley Dental
101 W. 7th Street, Suite 2F, Pennsburg, PA 18073

NOTICE OF PRIVACY PRACTICES
RESPONSIBLE PARTY 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/or 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 completed description of the uses and disclosures of my health information. I understand 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 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. 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.

PLEASE NOTE:

This form is NOT a notice or acknowledgement of financial responsibility.
Financial responsibility notice is on the reverse of this sheet.

Who should fill this form out? Who is the 'responsible party':

Patients over 18 years of age who are legally responsible for their own health information.

OR

The legal guardian (i.e., a parent or Power of Attorney) of a patient under 18 years of age or a patient over 18 years of age who is not legally responsible for their own health information.

Printed Name of Responsible Party:	PRINT HERE
Signature of Responsible Party:	SIGN HERE
Relationship of Responsible Party to Patient (circle or indicate):	**SELF PARENT OTHER: ________________**
Today's Date (MM/DD/YYYY):	MM / DD / YYYY
OPTIONAL: Printed Name(s) of Additional Person(s) with Whom to Share Health Information:	
Relationship of Additional Person(s) to Patient:	

AREA BELOW THIS TEXT FOR OFFICE USE ONLY

I attempted to obtain the Responsible Party's signature on this *Notice of Privacy Practices* acknowledgement but was unable to do so as documented below.

Today's Date (MM/DD/YYYY): Staff Initials:

Reason:

Perkiomen Valley Dental
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FINANCIAL POLICY

Financially Responsible Party: Please initial acceptance of each statement on the provided line.

All fees are due in full on the day services are rendered, unless other arrangements are made in advance. _____

Payment is accepted via cash, check, Visa, MasterCard, or Discover. _____

We will send a claim to your insurance company as a courtesy. If you have multiple insurances which coordinate benefits with one another, be sure to send us the EOB (Explanation of Benefits) from the primary insurance so we may go on to the secondary insurance. _____

While our office is happy to call your insurance company for an estimation of benefits as a courtesy to you, any information we provide is not a guarantee of benefits. No actual determination of benefits can be made until a claim is received and processed by your insurance company. _____

By signing and printing my name below, I certify that I understand and agree to the above financial policy.

____

PRINTED NAME OF RESPONSIBLE PARTY RELATIONSHIP TO PATIENT

____

SIGNATURE OF FINANCIALLY RESPONSIBLE PARTY DATE

NOTE: PLEASE ALSO COMPLETE HIPAA ACKNOWLEDGEMENT ON REVERSE

THANK YOU