I have read, fully understand, and agree to the financial policy of Digital Dentistry @ Southpoint. I also understand that I am financially responsible for any and all charges incurred.

Signature of Responsible Party____

Date____

Notice of Privacy Practices Acknowledgement

Digital Dentistry At Southpoint
249 E NC Hwy 54 Suite 220
Durham, NC 27713

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 acknowledge that I have received 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 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.

Patient Name: (Print) ____________________________

Relationship to Patient: ____________________________

Signature: ____________________________

Date: ____________________

I give permission for ____________________________________ to have access to my dental records.

Initial_________