NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Ferncreek Family Dentistry
Ngozika Daka, DMD, PA
4155 Ferncreek Drive, Suite 101
Fayetteville, NC 28314

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 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 the *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 times 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 this office restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that this office is not required to agree to my request restrictions, but if such agreement is made, this office is bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:
Date: Initials: Reason