

“Smiles change lives ...  
and we change lives everyday.”

**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 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 the office of Steve Childress II, DDS, PLLC and Associates 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 on the bottom of this page or [www.beckleydentist.com/HIPAA](http://www.beckleydentist.com/HIPAA) 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 (Printed): \_\_\_\_\_ 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:

<i>DATE</i>	<i>INITIALS</i>	<i>REASON</i>

**Steve Childress II, DDS**  
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