ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Seattle's Family Dentistry

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Tel No: 206-466-2424 Fax No: 206-466-5088

My signature confirms that I have been informed of my right to privacy regarding my protected health information, under the Health Insurance Portability & Accountability of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that 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: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

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For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other

SPECIAL CONSENT AND RELEASE FORM FOR TREATMENT

I hereby authorize Dr. Goraya, DDS, Associates, and Assistants as may be designated to perform any and all needed dental procedures and any other form of treatment, including appropriate anesthesia, they may deem necessary for the welfare and treatment of:

Name of Patient:_____

Procedures:

_____
_____
_____
_____
_____
_____

I consent to the dental examination, x-rays, consultation, and treatment by Dr. Goraya, Associates, and Assistants

I understand that the expected results of said treatment cannot always be guaranteed. If I desire I can discuss, to my satisfaction, the following

- The nature and character of the proposal treatment.
- The anticipated results of the proposed treatment.
- The recognized alternative forms of treatment.
- The recognized serious possible risks and complications of the treatment, and of the recognized alternative forms of treatment, including non-treatment.
- The anticipated date and time of proposed treatment.

I understand that I am free to withhold or withdraw consent to the proposed treatment at any time.

Witness: _____ Signature of person giving consent: _____

Date signed: _____ Time:_____ Relationship to patient (if applicable) _____

Are there any questions about the procedures, risks, etc.?
[ ]Yes [ ]No

No treatment will be performed until this consent has been executed. This will be permanently filed in the patient's dental record.