Brendan Bernhart, D.D.S., P.C.
Prosthodontics & Maxillofacial Prosthetics
3020 Hamaker Ct., Suite 510
Fairfax, VA 22031

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, Under the Health Insurance Portability and 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:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

2. Obtain payment from third party payers.

3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been provided the opportunity to review the Notice of Privacy Practices adopted by the office of Brendan Bernhart, D.D.S., P.C. containing a more complete description of the uses and disclosures of my health information. I understand that the office of Brendan Bernhart D.D.S., P.C., has the right to change its Notice of Privacy Practices from time to time and that I may contact the office of Brendan Bernhart D.D.S., P.C. at any time during the normal business hours at the address below to obtain a current copy of the Notice of Privacy Practice.

I understand that I may request in writing that the office of Brendan Bernhart D.D.S., P.C. restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the office of Brendan Bernhart D.D.S., P.C. is not required to agree to my requested restrictions, but if the office of Brendan Bernhart D.D.S., P.C. does not agree then the office of Brendan Bernhart D.D.S., P.C. is bound to abide by such restrictions.
Choose one of the following four options:

____ I do not authorize the office of Brendan Bernhart D.D.S., P.C. to discuss my billing with any other individual.

____ I authorize the office of Brendan Bernhart D.D.S., P.C. to discuss my billing/medical with my spouse or guardian.

____ I authorize the office of Brendan Bernhart D.D.S., P.C. to discuss my billing/medical information with immediate members of my family.

____ I authorize the office of Brendan Bernhart D.D.S., P.C. to discuss my billing /medical information with the following individuals;

Name:____relationship:_________

Name:____ relationship:_________

____

____

*Patient name: (PRINT)____

*Responsible party/Guardian:
(PRINT)____

*Signature:____

Date:___________________ Date of birth:________________________

____

I have been provided with the opportunity (ask at desk if you wish a copy) to obtain a copy of this acknowledgement form(initials):_________

____

The office of Brendan Bernhart D.D.S., P.C. attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement but was unable to do so as documented for the reasons below:

____

Date: Initials: Reason: