ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

GERALD T. CARLO, D.D.S.

I understand that under the HIPAA (Health Insurance Portability and Account and Ability Act of 1996), 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 health-care 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.

By signing below, I understand the Privacy Practices from GERALD T. CARLO, D.D.S.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Documentation of Failure to Obtain Signed Acknowledgement

On_____, I, _____ employee of GERALD T. CARLO, D.D.S. presented this Acknowledgement of Receipt of Notice of Privacy Practices form to patient _____. The patient refused to provide a signature when requested.