West Madison Dental
5610 Medical Circle, Ste. 10, Madison, Wisconsin

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of West Madison Dental. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that might occur in my treatment, payment for services, or in the performance of the office health care operations. The Notice of Privacy Practices also describe my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

West Madison Dental reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐ YES	☐ NO
SPOUSE/PARTNER ONLY	☐ YES	☐ NO
OTHER (PLEASE SPECIFY) _____	☐ YES	☐ NO

_____ _____

Name of Patient **Signature of Patient** or Personal Representative

_____ _____

Date Description of Personal Representative

Record of Acknowledgement not obtained for the following reason:

☐ Needed more time to review Notice of Privacy Practices.
☐ Wanted to consult with another person before signing.
☐ Unable to sign.
☐ Reason not given
☐ Other (explain)

Release of Insurance Benefits

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with insurance claims.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to West Madison Dental.

_____ _____

Name of Subscriber Signature of Subscriber or Personal Representative

_____ _____

Date Description of Personal Representative

West Madison Dental complies with the applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Atención: Si hablas a español, tienes a tus disposición gratis idioma ayuda servicios. Llame al (608) 441-6004

Xim: Yog koj hais lus txhuam, koj muaj ntawm koj pov tseg dawb lus pab cov kev pab. Hu rau los yog (608) 441-6004