NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT PATIENT CONSENT FORM

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct and plan my treatment and follow-up among healthcare providers involved, both directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge the "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information are available to me upon request from Dr. Avetoom's office. I understand that I may request in writing how my private information is used to carry out treatment, payment or health care operations.

Patient
Name_____Relationship_____

Signature_____Date_____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I, _____, acknowledge and understand that a copy of the Dental materials Fact Sheet dated October 2001 is available to me upon request from Dr. Avetoom's office.

Patient
Signature_____Date_____