NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Stephen H. Clark, II, D.D.S., Ltd
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Suite B
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702-732-2333

I understand that, under the Health Insurance Portability and Accountabiltiy 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:

*Conduct, plan and direct my treatment and follow-up amoung the multiple healthcare 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.

I understand I can request a comprehensive copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time 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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such resctrictions.

Patient Name_____

Signature_____Date_____
(Guardian/Self)

OFFICE USE ONLY

_____Patient declined to sign_____Office Manager Intials_____Date