

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

THOMAS V. MASSA D.M.D.
588 E. BAY AVENUE
MANAHAWKIN, NJ 08050

I understand that, under the Health Insurance Portability & 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:

- Conduct, plan and direct my treatment and follow-up among 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 have received, read and understand 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 Private 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 restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Thomas V. Massa, DMD and Associates

**588 East Bay Avenue
Manahawkin, NJ 08050
609-597-3500**

I give permission to the office of Thomas V. Massa, DMD and Associates, to leave reminders of appointments and any medication instructions with the following people or on my answering machine. I realize that I can modify this list at anytime by notifying this office in writing.

Yes _____

No _____

Please check ALL or ANY that apply:

() 1. _____ Phone # _____
Spouse

() 2. _____ Phone # _____
Parent

() 3. _____ Phone # _____
Child

() 4. _____ Phone # _____
Significant Other

() 5. _____ Phone # _____
Other & relationship to patient

Signature: _____ Date: _____