Dr. Corey J. Walther D.D.S., L.T.D.
Dr. Jessie Mathew D.D.S.
847-882-3683

AKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operation 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 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 healthcare operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name: ____

Relationship to Patient: ____

Signature: __________________________________ Date:______________

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____________________________ Date of Birth: __________

I request that all communications to me by **Corey J. Walther DDS** and/or his staff be handled in the following manner:

***Written Communications**: Address to: _________________________________

____

If the above address is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment.

***Oral Communication: Call:** Home #_______________________________
May we leave a message? Yes ____ No ____

Work # _______________________________
May we leave a message? Yes ____ No ____

Cell # _______________________________
May we leave a message? Yes ____ No ____

***Oral Communication: Call:** May we leave a message that you need pre-medication? Yes ____ No ____
May we leave a message that you have dental appointment? Yes ____ No ____
Would you like to receive email reminders/text messages? Yes_____No____
I do not want a reminder message left at all_________(initials)
I do not want a postcard sent_______(initials)

**I understand that the office may charge me should I fail to keep my appointment. *oral communications

---

OFFICE USE ONLY

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

Date: ____________________ Initials: __________ Reason: ______________________________