R. Peter Sonntag
Family Dentistry D.D.S.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under Health Insurance Portability and 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, 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 that I may contact this organization at any time 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 restrictions.

Patient Name _____ Relationship to Patient _____

Signature _____ Date _____

BROKEN APPOINTMENT POLICY

We are pleased that appointment times are in high demand. Because of this, we enforce a missed appointment policy to ensure that other patients receive care in a timely manner. Missed appointments and appointments that are cancelled without 24- hour notice are subject to a cancellation fee of $25. If two appointments are missed without notice, we will be unable to continue rescheduling. We are sorry for any inconvenience.

Signature _____ Date _____