Drs. Philip Wolkstein & Greg Wolkstein

Dentistry for Children and Young Adults

Acknowledgement of Receipt of the Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information (PHI). 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 the treatment directly and indirectly
- Obtain payment from third-party payers

I have been offered or read Philip Wolkstein, DMD, Inc., Greg Wolkstein, DDS, Dentistry for Children and Young Adults Notice of Privacy Practices containing more complete description of the uses and disclosures of my protected health information. I understand that Philip Wolkstein, DMD, Inc., Greg Wolkstein, DDS, Dentistry for Children and Young Adults has the right to change its Notice of Privacy Practices from time to time and that I may contact Philip Wolkstein, DMD, Inc., Greg Wolkstein, DDS, Dentistry for Children and Young Adults at any time to obtain a current copy of their Notice of Privacy Practices.

Please Print

Name: _____

Signature: _____

Date: _____

For Office Use Only

_____

We attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but were unable to do so as documented below.

Date: _____

Reason: _____

_____

Signature: _____