THE DENTAL
ANESTHESIA CENTER

Michael J. Hoffmann, DDS 314-560-2858
Victoria Q. Daugherty, DDS 314-302-3200
Sean M. Thoms, DMD, MS 314-448-5972
Office: 314-862-7844
www.dentalsleepstlouis.com

Acknowledgement — Receipt of Notice of Privacy Practices (HIPAA)

We are required by law to provide you with a copy of our Notice of Privacy Practices, which explains your rights and our legal duties concerning your protected health information and how we may use and disclose your protected health information.

1. Please sign this form to confirm you have received our Notice of Privacy Practices.
2. You do not have to sign this form if you do not want to. Our staff will sign it to confirm we provided, or made a good faith effort to provide, you with our Notice of Privacy Practices.

Date: _____

Expires in 1 Year of Date of Completion

Name of Person(s) The Dental Anesthesia Center can disclose your protected Health and Dental information with:

_____

_____

_____

Acknowledgement by Personal Representative

If you are a Personal Representative acting for the person named above please place your name, relationship and authority to act as Personal Representative for the person below and sign on the line provided to acknowledge receipt of our Notice of Privacy Practices by the person or by you on the person's behalf. Proof of your authority to act may be requested.

I received the Notice of Privacy Practices of The Dental Anesthesia Center.

_____

Signature

Printed Name/
Title of Personal Representative's
Authority to Act (If Applicable)

Confidential Communication Request

Name of Person: _____ Date: _____

The Dental Anesthesia Center is committed to protecting the privacy of your protected health information. Communications containing your protected health information might remind you of an upcoming appointment or they might have more detailed protected health information about you. Please use this form to let us know how and where you would like to receive communications of your protected health information from us. We will agree to any reasonable request.

We will communicate with you by the following methods of communication:

U.S. Mail

Home Telephone Service

Home Telephone — Voicemail of Answering Machine

Work Telephone

Work Telephone — Voicemail or Answering Machine

Cell Telephone

Email

Text Message

Other Methods of Communication

You may ask us to communicate with you by other methods or locations. We will agree to a reasonable request however, if the method you request involves additional cost you must explain how payment will be handled and our agreement may be conditioned on this payment information.

I request to receive communication of my protected health information by the method described in the box below.

Note: You must provide specific details including, if necessary, information about how payment will be handled.

Signature, Individual/Personal Representative

X _____ Print Name: _____