Mengedoth Dental, PC

www.drdanmengedoth.com
office@drdanmengedoth.com

2585 23rd Ave. S, Suite C • Fargo, ND 58103-6172 (701)356-1280

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT(HIPAA)

Patient Name: ______________________ ______________________ ____ ______________________

Last First MI Preferred Name

I grant my permission to Daniel L. Mengedoth, DDS, Ltd. to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

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 that treatment directly and indirectly.
-Obtain payment from third-party payers.
-Conduct normal healthcare operations such as quality assessments and physician certifications.

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 Mengedoth Dental is not required to agree to my requested restrictions, but if you do agree then the practice is bound to abide by such restrictions.

☐ ***I have 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 to stay in compliance with State and Federal laws and regulations. I may contact this organization at any time to obtain a current copy of the Notice of Private Practices. It is available by request at our front desk or by contacting our office by phone (701-356-1280) or email (office@drdanmengedoth.com).**

Patient's Signature:

Signature ____ **Date** ____________

Relationship to patient (if signed by representative of patient):

____

____

Response Date: ____/____/________