BARRINEAU D.D.S.
Family Dental Care & Wellness

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered an electronic copy of the office's Notice of Privacy Practices, as part of my new patient paperwork via DocuSign. The printed version of these practices can also be found on the office website: drnbarrineau.com or within the labeled binder in the office lobby for patient review/copies. Barrineau, DDS, PA. Family and Cosmetic Dentistry provides this form to comply with the HIPAA requirements. Please review the Notice of Privacy Practices before signing this document.

By signing this form, you acknowledge that we may use and disclose your protected health information for treatment, payment, and healthcare operations. You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment, and healthcare operations.

I give permission for Barrineau, DDS, PA., Family and Cosmetic Dentistry to:

- Call/leave message at my home telephone number:_____
- Call/leave message/text on my mobile number:_____
- Call/leave message on my work number:_____
- Send me an unencrypted email:_____
- Other:_____

I give permission for you to speak with the individuals about my care:
(Note: Please notify us if you wish to make a change in the future.)

Name	Relationship	Phone Number

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Print Name of Patient or Legally Authorized Representative Legal Relationship

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~**Office Use Only**~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

- Patient/Representative refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify):_____