BENJAMIN T. PETERSON, DDS, PC
271 SW 13th St. | Ontario, OR | 97914
(541) 889-9407 | www.bpetersondds.com

Welcome to Our Office!

Our office is committed to providing the highest quality dental care at a reasonable cost. Thank you for trusting us with your care. Please take a few minutes to read and complete the following forms. If you have any questions or need assistance, please feel free to ask. Once again, welcome!

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability Act ("HIPAA"), I have certain rights to privacy with respect to my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in my treatment, directly and indirectly.
2. Obtain payment from insurance companies or third-party payors.
3. Conduct normal healthcare operations such a quality assessments and physician certifications.

I have received, read and understand this *Notice of Privacy Practices*. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the address above to obtain a current copy of its *Notice of Privacy Practices*.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand that this office is not required to agree to my requested restrictions, and that if this office does agree, that it is bound by such restrictions.

Failed Appointment / Cancellation Policy

Failure to appear for a scheduled appointment or cancellations made within 24 hours of an appointment may result in a fee according to the procedure and the amount of time reserved for you or dismissal from our office.

Acknowledgment

By my signature below I acknowledge that I have read and understand the foregoing *Notice of Privacy Practices* and Failed Appointment / Cancellation Policy:

_____ _____

Signature of Patient or Responsible Party Date

_____

Please Print Name of Patient or Responsible Party