



**WARM  
SPRINGS  
DENTAL**

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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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 PHI can and will be used as outlined in the *Notice of Privacy Practices* that I have read.

I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may obtain a current copy at any time.

I understand that I may request in writing that this practice restricts how my PHI is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree with my restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this *Notice of Privacy Practices Acknowledgment*, but was unable to do so as documented below:

Date	Initials	Reasons