MK PERIODONTICS AND IMPLANTS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

- **I authorize the release of my dental records from MK Periodontics and Implants, Drs Karbakhsch and/or Su to individuals involved in my dental care. I further authorize the release of records from any individuals to Drs. Karbakhsch, Su and/or associates.**
- **I authorize release of medical information to insurance companies needed for the processing of your claims.**
- **I authorize insurance payments to be made directly to MK Periodontics and Implants, Drs. Karbakhsch and/or Su. I understand that I am responsible for any unpaid balance.**
- **I authorize photos, slides, filming, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry. My identity will not be revealed to the general public.**
- **I am aware that should I not provide adequate notice to change an appointment, I may be charged a fee. (Seven business days for a surgical appointment and two business days for a cleaning appointment)**
- **I am aware of and have received notice of the Health Insurance Portability and Accountability Act (HIPPA)**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records or get more information about it by contacting us.
By signing below I acknowledge receipt of the Notice of Privacy Practices.

AUTHORIZATION FOR APPOINTMENT CONFIRMATION

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, appointment post cards sent through the mail, messages left with roommate/family members, and voicemail messages. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's appointment time and date, or need for an appointment may be included.

By my signature below, I authorize the office of MK Periodontics and Implants, Drs Karbakhsch and/or Su and their staff to confirm my appointment and remind me of the need for an appointment in the above mentioned ways, for the duration of my treatment with their office.

Patient's Signature ____________________ **Date** __________

Parent or Guardian (if Patient is a Minor) ____________________ **Date** __________

This form will be retained in your dental record.