ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been informed of the office's Privacy
(Print Patient's Name)
Practices and Patient Bill of Rights and received a copy. Whom may we speak with on the patient's behalf? _____

_____(You may list more than one name).

_____
(Printed Name-Patient/Parent/Guardian)

_____
(Signature-Patient/Parent/Guardian)

_____
(Date)

_____
(Expiration Date)

At any time the above listed Patient (if of legal age)/Parent/Guardian has the right to revoke his/her consent to release protected information. A written, signed, and dated notice revoking the authorization needs to be submitted to this office.

You may refuse to sign this acknowledgement

Messages:

I give my consent to the physicians and staff of Beautiful Smiles Family Dental Center to leave detailed messages or discuss scheduling, treatment/finances, surgery, or other information regarding my care, account, or insurance as follows:

____ On voicemail at home
____ On voicemail at work
____ Cell phone
____ E-mail
____ I do not consent to detailed messages being left at my home, work, email, or cell phone.

_____
Signature of Patient/Parent/Guardian Date

FOR OFFICE USE ONLY

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

____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgment
____ An emergency situation prevented us from obtaining acknowledgment
____ Other (please specify)