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Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that all health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to acknowledge receipt of same. *You may refuse to sign this acknowledgement form.*

I hereby acknowledge that I have received a copy of the office Notice of Privacy Practices provided by Prestige Dental. I have reviewed the contents of this document and have been given the opportunity to address all questions and concerns regarding this Notice with my doctor prior to my treatment.

Patient Name _____

Patient Signature _____ Date _____

If Minor:

Name of Parent or Guardian _____ Relationship _____

Signature of Parent or Guardian _____ Date _____

Office Use Only:

Written acknowledgement was not obtained.

- o Patient refused to sign
- o Emergency situation
- o Unable to communicate with patient
- o Other _____

_____

Staff Name _____

Staff Signature _____ Date _____