CHOLLA
FAMILY DENTISTRY

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

**If the patient is less than 18 years of age, a parent or legal guardian must sign.**

I, _____, have received a copy of this office's Notice of Privacy Practices
(Please Print Patient's Name)

_____
(Signature of Patient or Parent/Legal Guardian)

_____
(Date)

**For Patients who need pre-medication only:**
I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox or with whomever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office will mail to me.

_____
(Signature of Patient or Parent/Legal Guardian)

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**For Office Use Only**

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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
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Patient reviewed Privacy Practices, but elected not to take a copy home
- ❑ Other (Please Specify)

Employee signature: _____ Date: _____

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