ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices. This includes the situation where your first date of service occurred electronically.

I have received Richardson DMD's Privacy Notice.

Patient Printed Name **Patient Date of Birth**

Patient Signature **Todays Date**

Parent or Legal Guardian Signature **Parent or Guardian Printed Name**

Additional Minor(s) or Ward(s) who Guardian Will Assure Have Access to Privacy Policy.

Name **Date of Birth** **Name** **Date of Birth**

Name **Date of Birth** **Name** **Date of Birth**

Protecting Your Privacy

I am 18 years old or older. I authorize the dental staff to discuss the patient's dental treatment with the following people unless/until I withdraw this authorization in writing. Check all that apply and provide name(s).

[ ] parent(s) _____

[ ] legal guardian(s)_____

[ ] spouse_____

[ ] other_____

*****************Done with Patient Portion – Office Use Only***************************

Richardson DMD staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice? [ ] Yes [ ] No

2. If you answered "No" above, please explain why the patient did not sign an acknowledgement form and [PROVIDER'S] efforts in trying to obtain the patient's signature (check all that apply):

[ ] Patient Unable to Comprehend
[ ] Patient Communication Barrier
[ ] Legal Representative not Available
[ ] Other:_____
[ ] Patient/Legal Representative Left before Signature Obtained
[ ] Emergency Admission/Patient Not Present for Registration
[ ] Patient bypassed Registration – Not Available

3. Completed by:

_____ _____ _____

Staff Member Signature Staff Member Name Date