

ACKNOWLEDGMENT FORM
24TH STREET DENTAL CARE

THIS FORM IS USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF
OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR
GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

NAME OF PATIENT (PLEASE PRINT)

SIGNATURE OF PATIENT

DATE

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

BELOW THIS LINE FOR OFFICE USE ONLY

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN
THE ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

SIGNATURE

Title

Date