

# La Grange Dental Associates, P.C.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

I, (Print) Your Name: \_\_\_\_\_ have received a copy of this office's

Notice of Privacy Practices. Sign: \_\_\_\_\_

Date: \_\_\_\_\_

### Please Check One of the Following

- You may communicate with the following individuals relating to my medical or payment information.

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact Info: PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

- Please do not discuss my medical or payment with the following individuals. \_\_\_\_\_
- Please do not discuss my medical or payment information with anyone.

### For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)