HIPAA PRIVACY ACT
ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, _____ [Please print full legal name here] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of **Riverside Dental Group** (the "Provider"), and have been offered a copy of such policy to keep for my records.

_____ [Please initial here] I hereby acknowledge that I have received the Policy and understand its terms and conditions.

_____ [Please initial here] I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgement, the Dentist may still provide treatment to me.

_____ _____ _____
Patient Account # and Name Signature of Patient Date

For Office Use Only

I _____attempted to obtain the written acknowledgment of receipt of the Policy of Provider, but acknowledgement could not be obtained because:

_____ [Please initial here] Patient or Patient's legal representative refused to sign.

_____ [Please initial here] Patient or Patient's legal representative could not be communicated with sufficiently to obtain acknowledgement.

_____ [Please initial here] Emergency circumstances prevented securing acknowledgement.

_____ [Please initial here] Other (Please specify) _____

_____

_____

_____ _____ _____
Print Name & Title Signature of Provider Representative Date