

Dental Arts S.C.
404 Wisconsin Avenue
Amery, WI 54001
715-268-7177
www.amerydental.com

Section A: The Patient.

Name: _____

Address: _____

Telephone: _____ Cell Phone: _____ E-Mail _____

Contact Person (Spouse, Parent, Adult Child, sig.other etc.) _____

Telephone: _____

Section B: Acknowledge of Receipt of Privacy Practice Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relations to Individual: _____

Section C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

Describe the reason why the individual would not sign the form: _____

Signature.

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE