



**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES
(HIPAA)**

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

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

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

Signature of Patient or Patient's Legal Representative

Date

For Office Use Only

I, _____, acting as _____
[Please print full legal name here] [Please print relationship to or official position with Provider]

for Provider attempted to obtain the written acknowledgment of receipt of the Policy on
_____ but acknowledgment could not be obtained because:
[Please insert date attempt was made]

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

_____ Communication barriers with Patient or Patient's legal representative prohibited
[Please initial] obtaining acknowledgment.

_____ Emergency circumstances prevented securing acknowledgment.
[Please initial]

_____ Other (Please specify) _____
[Please initial]

Signature of Provider or Provider Representative

Date

4/24/2014