1st Advantage Dental New York

HIPAA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I_____(The "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of 1st Advantage Dental New York (the "Provider"), and have been offered a copy of such policy to keep for my records.

_____ I hereby acknowledge that I have read 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 term and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.
(Please initial here)

_____
Signature of Patient Date

For Practice 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 written acknowledgement of receipt of the Policy of Privacy on

_____ but acknowledgement could not be obtained because:
(Please insert date attempt was made)

_____ Patient or Patient's legal representative refused to sign.

_____ Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgement.

_____ Emergency circumstances prevented securing acknowledgement

_____ Other (Please Specify)

_____

_____

_____
Signature of Provider Representative Date