



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices Allegiance Dental, Inc.
Allegiance Dental reserves the right to modify the privacy practices outlined in the notice.

Name of Patient: _____ Date of Birth: _____

Name of Person Signing Acknowledgement: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Signature: _____

Relationship: Self Mother Father Legal Guardian

Date: _____

OFFICE USE ONLY (If not signed above)

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices.
The
acknowledgement was not obtained because:

The patient declined to sign the acknowledgement.

Other

Name of Patient (Please Print): _____

Name of Allegiance Dental Employee: _____

Date: _____