FOX DENTAL LTD.
Dentistry that Makes a Difference.SM

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I had the opportunity to review and/or obtain a copy of this office's Notice of Privacy Practices.

Print Name:____ Date of Birth: __________________

Signature: ____

Relationship to patient (if signed by personal representative of patient):__________________________

Date:____

☐ ***Please check the box if we are able to leave a message with medical & financial information on phone numbers***

Please list individuals names that we are allowed to release financial and medical information to:

1____ 2______________________________________

** You May Refuse to Sign This Acknowledgment**

~~~~~~

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify): ____
____
____
~~~~~~