PEDIATRIC DENTISTRY of Lewisburg

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this acknowledgement.

Patient Name _____ Date of Birth _____

I have received a copy of Pediatric Dentistry of Lewisburg's Notice of Privacy Practices.

_____
(Signature)

_____
(If a minor patient, please print name of person signing)

_____
(Date)

**FOR OFFICIAL 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

____ Communication barriers prohibited obtaining acknowledgement

____ An emergency situation prevented obtaining acknowledgement

____ Other _____

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