1367-B EAST GARRISON BOULEVARD
GASTONIA, NC 28054-5144
980.320.8479
WWW.GASTONIAPEDIATRICDENTISTRY.COM

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name

____

Last First Middle Preferred

Address____

____

City State Zip

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices:

Signature____Date____________

____

For Office Use Only

____

__ An emergency existed and obtaining a signature was not possible at the time.

__The individual refused to sign.

__A copy was mailed with a request for signature.

__We were unable to communicate with the patient for the following reasons:

____

Signature of staff member who was unable to obtain Acknowledgement of Receipt of Notice of Privacy Practices.

Signature____Date____________________