Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

Dr. Maria Connoyer DMD PC
Dr. Stephanie Henricks DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse To Sign This Acknowledgement"

Do we have your permission to mention to others you were in the office? (According to the HIPAA guidelines, we cannot acknowledge you are in the building. May we tell someone who calls for you that you are here, for purpose of messages, picking you up, etc?)

(Circle One) YES NO

Do we have permission to discuss your treatment or financial arrangements with your spouse?

(**Circle One**) **YES NO**

If yes please list name_____

Relationship_____

Do we have permission discuss your treatment with your direct family?

(**Circle One**) **YES NO**

If yes please list names_____

Relationship_____
Do we have permission to discuss financial arrangements with your family?

(**Circle One**) **YES NO**

If yes please list names_____

Relationship_____

Do we have permission to send appointment reminder cards in the mail?

(Circle One) YES NO

Do we have permission to leave messages about upcoming appointments?

(Circle One) Yes NO

Patient's Name_____DOB_____

Parent signature if under 18_____

I _____, have received a copy of this office's Notice of Privacy Practices.

_____

(Please Print Name)

_____

(Signature) Date