



PART A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

PART B: Acknowledgment of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from Distinctive Dental Concepts.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

PART C: Good Faith Effort to Obtain Acknowledgment of Receipt by Distinctive Dental Concepts.

Describe your good faith effort to obtain the individual's signature on this form: _____

Describe the reason why the individual would not sign this form. _____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

**ACKNOWLEDGMENT OF RECEIPT OF
PRIVACY PRACTICES NOTICE**