

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of K. Scott Williams, D.D.S., P.A.'s Notice of Privacy Practices effective 3/1/17.

Patient's Name (please print) _____

Signature of Patient

Date Signed

I am a parent or legal guardian of _____ (patient's name). I have received a copy of K. Scott Williams, D.D.S., P.A.'s Notice of Privacy Practices effective 3/1/17.

Parent or Legal Guardian's Name (please print) _____

Relationship to Patient: Parent Legal Guardian

Signature of Parent or Legal Guardian

Date Signed

I authorize the doctor and his staff to contact me by phone email mail (check all that apply)

If the patient or the patient's parent/legal guardian did not sign above, staff member must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and what efforts were used to obtain the signature.

Notice of Privacy Practices effective 3/1/17 given to individual on _____ (date)

In Person Email Mail Other _____

Reason patient or patient's parent/legal guardian did not sign this form:

Did not want to sign
 Did not respond after more than one attempt
 Other _____

Staff Member's Name (please print)

Title

Signature of Staff Member

Date Signed