Lakeside Dental Care

HIPAA PRIVACY

ACKNOWLEDGE OF RECEIPT

OF

NOTCE OF PRIVACY PRACTICES

I, _____ (The "patient" or "patient's legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of Lakeside Dental Care (the "Provider") and have been offered a copy of such policy to keep for my records.

_____I hereby acknowledge that I have read the Policy and understand its terms and conditions.
(Please initial here)

_____I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge
(Please initial here) any of the terms or conditions of the Policy. I understand that even though I may refuse to sign this acknowledgement, the Provider may still provide treatment to me.

_____
Signature of the Patient Date

_____

For Practice Use Only

_____

I, _____ acting as _____
(Please give full legal name here) (Please print relationship to or official position with Provider)

For Provider attempted to obtain written acknowledgement of receipt of the Policy of Privacy on _____ but acknowledgement could not be obtained because:

_____ Patient or Patient's legal representative refused to sign.

_____ Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgement.

_____ Emergency circumstances prevented securing acknowledgement.

_____ Other (please specify)

_____

Signature of Provider Representative Date