



1839 East Capiol Avenue . Bismarck, ND 58501 701-255-4850

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

****You may Refuse to Sign This Acknowledgement****

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

*I give the following individuals permission to receive information on my dental care, appointments, and dental bills:

(Please print name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

