PATIENTS ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND ADA LANGUAGE ASSISTANCE

ACKNOWLEDGEMENT OF RECEIPT

Date

Patient Name: _____

I acknowledge that I have read and been offered a copy of Adventure Dental's HIPAA Notice of Privacy Practices and the ADA Language Assistance.

_____ _____

Parent/Guardian Signature Date

If you are signing as a personal representative of the patient, describe your relationship to the patient or the source of your authority to sign this form.

Source of Authority/Relationship to patient:_____