

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Emhardt Pediatric Dentistry, LLC

Acknowledgement	
<p>I, _____, hereby acknowledge that I have received and reviewed a copy of Emhardt Pediatric Dentistry <i>HIPAA Notice of Privacy Practices</i>.</p> <p>I understand that Emhardt Pediatric Dentistry <i>HIPAA Notice of Privacy Practices</i> may change periodically and that I am entitled to receive a copy of Emhardt Pediatric Dentistry revised <i>HIPAA Notice of Privacy Practices</i> upon request.</p> <p>I understand that, if I have questions about Emhardt Pediatric Dentistry <i>HIPAA Notice of Privacy Practices</i>, I may contact Jeanette Whalen at jeanette@emhardtpediatricdentistry.com</p> <p>I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Emhardt Pediatric Dentistry will not refuse treatment if I refuse to sign this Acknowledgement.</p> <p>I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Emhardt Pediatric Dentistry's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Jeanette Whalen, noted above, for assistance.</p>	
_____ Patient Signature	_____ Date
_____ Signature of Personal Representative	_____ Print Name of Personal Representative
_____ Relationship of Personal Representative to Patient	

FOR OFFICE USE ONLY		
Emhardt Pediatric Dentistry made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its <i>HIPAA Notice of Privacy Practices</i> . In spite of these efforts, Emhardt Pediatric Dentistry was unable to obtain a signed Acknowledgement for the following reason(s):		
<input type="checkbox"/> Refusal to sign Acknowledgement on _____, 20____.		
<input type="checkbox"/> Communications barriers prohibited us from obtaining a signed Acknowledgement.		
<input type="checkbox"/> An emergency situation prohibited us from obtaining a signed Acknowledgement.		
<input type="checkbox"/> Other (Describe): _____		
Date Received	By	Patient ID