Acknowledgement of Receipt of Notice of Privacy Practices

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Wexford Family Dentistry
1000 Brooktree road, # 101, Wexford, PA 15090
Phone: 724-935-3610

You May Refuse to Sign This Acknowledgment

I have been provided the opportunity to read and receive a copy of this office's Notice of Privacy Practices.

Patient's Name (please print): ______________________________

Signature: ______________________________ Date: ____________

If acknowledgement is by patient's personal representative:

Personal Representative's Name (please print): ______________________________

Relationship to the Patient: ______________________________

I certify that I have the legal authority under applicable law to act on behalf of the patient identified above.

Signature of Personal Representative: ______________________________ Date: ____________

If you would like a copy of our Notice of Privacy Practices for your personal records, please:

- ask our staff for a copy to go!

It is our office policy not to allow cell phones, video recorders or cameras into our clinical areas, this is to ensure that our patient privacy is kept at all time. We apologize for any inconvenience this may cause you.

FOR DENTAL 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): ______________________________