

"Creating healthy, beautiful smiles....for a lifetime."

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgment ****

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Metro Dental Associates. A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please print your name

Please sign your name

Date of your signature

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority
_____.

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer,
at:

Privacy Officer for Metro Dental Associates
84 Maple Avenue
Morristown, NJ 07960
(973)538-2563
Fax (973)539-7558

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

- It was emergency treatment _____
- I could not communicate with the patient _____
- The patient refused to sign _____
- The patient was unable to sign because _____
- Other (please describe) _____

Signature of privacy officer