Central Park Dentistry
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I acknowledge that I have received a copy of this office's HIPPA Notice of Privacy Practices.

_____ _____ _____

{Please Print Name} {Signature} {Date}

OR

_____

{Signature of Representative/Guardian}

Authority of Representative/Guardian to Sign for Patient (check one):

❑Parent ❑Guardian ❑Power of Attorney ❑Other: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

_____

CONSENT FOR TREATMENT

I hereby grant authority to Dr. Lala, Dr. Hansen, Dr. Thackery, Dr. Kolker and/or Dr. Brayton to administer any treatment: and to administer such anesthetics and perform such operations as may be deemed necessary or advisable in the diagnoses and treatment of me. I understand that I will be consulted before any treatment as rendered.

{Patient or Parent of Minor} **{DOB}** **{Date}**