

Dr. Thomas Capsey, DMD
***ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES***

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Name

Signature

Date

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)

I authorize payment directly to the dentist of any insurance payments otherwise payable to me. I release any information concerning my dental records and credit history. I understand that I am responsible for all costs of dental treatment.

RESPONSIBLE PARTY FOR PATIENT:

Name and address: _____

Signature: _____ Date: _____

(If under 18, Parent or Guardian Signature Required)