West Suburban Family Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPPA PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's ***HIPPA Notice of Privacy Practices*** and I have read and acknowledge the information that it provides.

Print Patient Name: _____

Signature: _____Date: _____
*If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below

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ACKNOWLEDGEMENT OF RECEIPT OF OFFICE POLICIES, AGREEMENTS & AURTHORIZATIONS

You May Refuse to Sign This Acknowledgement

I have received a copy of this *office's* ***Patient Acknowledgements, Agreements & Authorizations*** and I have read and agree to the terms it provides. To the extent permitted by law, I consent to West Suburban Family Dental use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluation and administering claims for benefits. I further authorize and direct payment to West Suburban Family Dental of the dental benefits otherwise payable to me.

Print Patient Name: _____

Signature: _____Date: _____
*If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below

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Responsible Party (If patient is under 18 or disabled)

First Name: _____ MI:_____ Last Name: _____

Street: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Work: _____ Cell:_____

Relationship to Patient: _____