HIPAA Notice of Privacy Practices Acknowledgement of Receipt

I HEREBY ACKNOWLEDGE THAT I HAVE READ A COPY OF THEIS OFFICE'S NOTICE OF PRIVACY PRACTICE.

Signed:_____Date:_____

PRINTED NAME:_____ Relationship to Patient:_____
Name of
Patient/Patients:_____

ANYONE UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN TO EVERY APPOINTMENT. The Parent/Legal guardian is required to BE PRESENT IN THE OFFICE for the ENTIRE APPOINTMENT, YOU CANNOT LEAVE YOUR CHILD. During the appointment you may have to make treatment decisions for the patient and fill out important medical information regarding the patient. We understand that you may need other family members to bring your child to his/her appointment. If you do, please understand they MUST be able to fill out all paperwork correctly and have permission to make any treatment decisions while at this appointment. Please list any/all people to whom you give permission below.

I also give KIDS ZONE DENTISTRY permission to speak to the following people listed (if any) regarding my child's health information and allow them to make decisions regarding their dental needs.

Name:_____
Relationship to Patient:_____ Phone:_____

Name:_____
Relationship to Patient:_____ Phone:_____

Name:_____
Relationship to Patient:_____ Phone:_____

Name:_____
Relationship to Patient:_____ Phone:_____

Refusal to sign:_____
Refusal
reason:_____