NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: ________________

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, Office Policy and Financial Policy.

__________________________ __________________________
Patient Name (Print) Patient Signature

If completed by a patient's Guardian, please print and sign your name in the space below

__________________________ __________________________
Guardian's Name (Print) Guardian Signature

____
Relationship

For Magical Smiles use only

Complete this section if this form in not signed and dated by the patient or patient's guardian.

I have made a good faith effort to obtain a written acknowledgement of receipt of Magical Smiles Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other ______________

__________________________ __________________________
Employee Name Date

408 Dix Road Jefferson City, MO 65109 Phone: 573.638.3897