

~~-----Bill Hanna, DDS-----~~
Acknowledgement of Receipt of Notice of Privacy Practices
*****You May Refuse to Sign this Acknowledgement*****

I, _____
have read and received a copy of the Notice of Privacy Practice at Bill Hanna, DDS.

Please Print Patient's Name Date

Signature of Patient or Guardian *(if patient under 18)* Print Guardian's Name *(if patient under 18)*

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