ARIZONA
DENTAL DESIGN

Todd J. Sick, DDS

Acknowledgement of Receipt of Notice of Privacy Practices
You May Refuse to Sign This Acknowledgement
If the patient is under18 years of age, a parent or legal guardian must sign.

I_____ (Please Print Patient's Name) have received a copy of this office's Notice of Privacy Practices.

Signature of Patient or Parent/Legal Guardian: _____

Date: _____

For Patients who need pre-medication only:
I am authorizing this office to call me and remind me to take my pre-medication before my dental appointment. They may leave a message for me regarding this information at any number that I have supplied to them. They may leave a message on any answering machine, voice mailbox, or with whoever answers the telephone. I also authorize this office to remind me of my pre-medication on any postcard reminders that the office mail to me.

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
- Patient reviewed Privacy Practices but elected not to take a copy home
- Other

Employee Signature: _____

Date: _____

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