ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Catharine Goodson, DDS, PLLC’s Notice of Privacy Practices effective 3/1/17.

Patient’s Name (please print)

___________________________

Signature of Patient

Date Signed

I am a parent or legal guardian of _________________________________ (patient’s name). I have received a copy of Catharine Goodson, DDS, PLLC’s Notice of Privacy Practices effective 3/1/17.

Parent or Legal Guardian’s Name (please print)_______________________________

Relationship to Patient:       ☐ Parent       ☐ Legal Guardian

___________________________

Signature of Parent or Legal Guardian

Date Signed

I authorize the doctor and her staff to contact me by ___phone ___email ___mail  (check all that apply)  

I authorize the doctor and her staff to contact me by ___phone ___email ___mail  (check all that apply)  

If the patient or the patient’s parent/legal guardian did not sign above, staff member must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and what efforts were used to obtain the signature.

Notice of Privacy Practices effective 3/1/17 given to individual on _________________________ (date)

☐ In Person ☐ Email ☐ Mail ☐ Other _________________________________

Reason patient or patient’s parent/legal guardian did not sign this form:

☐ Did not want to sign
☐ Did not respond after more than one attempt
☐ Other

___________________________

Staff Member’s Name (please print)                      Title

___________________________

Signature of Staff Member                                Date Signed