

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

ALL SMILES FAMILY DENTAL
537 E DUNDEE RD
PALATINE, IL 60074

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of ALL SMILES FAMILY DENTAL's *HIPAA Notice of Privacy Practices*.

I understand that ALL SMILES FAMILY DENTAL's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of ALL SMILES FAMILY DENTAL's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about ALL SMILES FAMILY DENTAL's *HIPAA Notice of Privacy Practices*, I may contact DR SANDHYA PALLAM, 537 E DUNDEE RD, PALATINE, IL 60074, Ph: 847-907-0585.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that ALL SMILES FAMILY DENTAL will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding ALL SMILES FAMILY DENTAL's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask DR. SANDHYA PALLAM, noted above, for assistance.

Patient Signature	Date
Signature of Personal Representative	Print Name of Personal Representative
	Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

ALL SMILES FAMILY DENTAL made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, ALL SMILES FAMILY DENTAL was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgement on _____, 20____.
- Communications barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): _____

Date Received	By	Patient ID