Pediatric Dentistry of Flower Mound

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of this office's **Notice of Privacy Practices.** If I am a minor unaccompanied by a parent or guardian, I will accept this Notice and provide it to my parent or guardian.

Please Print Your Name: _____
LAST FIRST MI

Your Signature: _____ Today's Date: _____

Name of Patient:	**DOB:**
_____	_____
_____	_____
_____	_____
_____	_____

Please list any other person (or persons) that may present your child for treatment, that may consent to such treatment, and with whom we may discuss treatment, recommendations, and/or billing matters pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164 and Texas Family Code, Title 2, Chapter 32, Section 32.001 – Consent to Treatment of Child by Non-Parent:

Name:	**ID# & Type of ID:**
_____	_____
_____	_____
_____	_____
_____	_____

Do Not Write Below— 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 us from obtaining the acknowledgement.
- ☐ Emergency situation prevented us from obtaining the acknowledgement.
- ☐ Other (Specify) _____

Received by _____ Date _____