Alan K. Kuwabara, D.D.S., PLLC

Child and Adolescent Dentistry

Please read the following and sign prior to treatment.

The Patient:

Name: _____

Acknowledgment of Receipt of Privacy Practices:

I, _____, acknowledge that I have received a notice of privacy practices from the above-named practice.

Signature: _____ Date: _____

Personal Representative's Name: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgment of Receipt

Describe your good faith effort to obtain the individual's signature on this form:

_____

_____

Describe the reason why the individual would not sign this form:

_____

_____

Signature

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES