R. SCOTT SCHALO D.D.S., M.S.
PERSONALIZED ORTHODONTICS

Acknowledgement of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices. (Available upon request)

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare procedures involving our office. The Notice of Privacy you have viewed describes these uses and disclosures in detail. I acknowledge that I have reviewed the *Notice of Privacy Practices* that you have provided which describes these uses and disclosers in detail.

Print Patient's Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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