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We are required by the Health Insurance Portability and Accountability Act (HIPAA) to both offer our patients a copy of our Notice of Privacy Practices and to obtain your signature that we did offer you this document.

A copy of our Notice of Privacy Practices is available to you and is displayed at all times in our reception area.

This acknowledgement will be kept in your dental file. If you would like a copy, please feel free to request one at any time.

Thank you.

Print Patient Name _____

Patient and/or Guardian Signature _____

Date _____