

**ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I, _____ have received a copy of
(Name of Patient)

Juli Powell DDS & Ada Tiller DDS, PC **Notice of Privacy Practices**

Dr. Powell and Dr. Tiller would like to check on their patients after treatment.
If you are not available, do we have your permission to:

_____ Leave a message on your home phone

_____ Leave a message on your cell phone

_____ Leave a message on your email

_____ Check this area if you are requesting we do not leave messages regarding
your dental treatment

(Signature of Patient or Parent/Guardian if Minor)

Date

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our
Notice of Privacy Practices, but it could not be obtained for the following reasons:

_____ Patient refused to sign

_____ Emergency situation kept us from obtaining the patients signature

_____ Language barriers kept us from obtaining the patient's signature

_____ Other _____