6400 Arlington Blvd, Suite 80, Falls Church, VA 22042
Phone: 703.533.5511 • fallschurchkids.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE
You May Refuse to Sign This Acknowledgement

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practice for Falls Church Pediatric Dental Center. A copy of this signed, dated Acknowledgement shall be as effective as the original.

____

Please print your name

____

Please sign your name

____

Date of your signature

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority

____

If you have any questions about this form or attached Notice, please contact our privacy officer at:

Falls Church Pediatric Dental Center
Attn: Privacy Officer
6400 Arlington Blvd, Suite 80
Falls Church, VA 22042

OFFICE USE ONLY

As privacy officer, I attempted to obtain the patients' (or representative) signature on this Acknowledgment but did not because:

It was emergency treatment ______
I could not communicate with the patient ______
The patient refused to sign ______
The patient was unable to sign because ______
Other (please describe) ______

____

Signature of privacy officer