Central Park Dentistry Osage

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I acknowledge that I have received a copy of this office's HIPPA Notice of Privacy Practices.
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{Please Print Name} {Signature} {Date}

OR

{Signature of Representative/Guardian}
Authority of Representative/Guardian to Sign for Patient (check one):

❑Parent ❑Guardian ❑Power of Attorney ❑Other: _____ **PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:** Name: _____ Relationship: _____
Name: _____ Relationship: _____

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)

CONSENT FOR TREATMENT

I hereby grant authority to Dr. Lala, Dr. Hansen, Dr. Lehmann and/or Dr. Young to administer any treatment: and to administer such anesthetics and perform such operations as may be deemed necessary or advisable in the diagnoses and treatment of me. I understand that I will be consulted before any treatment as rendered.

_____

_____

{Patient or Parent of Minor} {DOB} {Date}