

Plantsville Family Dental

Thomas L. DeRienzo, D.M.D.
15 Cornerstone Court, Unit 1
Plantsville, CT 06479

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Dental Record Number: _____

Social Security Number: _____

Date of Birth: _____

“I hereby acknowledge that I have received a copy of this practice’s Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this Notice of Privacy Practice should it be amended, modified or changed in any way.”

Patient Signature: _____ Date: _____

Or Signature of Patient’s Representative: _____ Date: _____

Please indicate if it is acceptable for telephone messages to be left on your home answering machine/voice mail regarding appointments:

YES or NO

Please indicate if it is acceptable for office personnel to speak with your spouse or other designated person regarding your care/results/appointments:

YES or NO

Name(s): _____ Relationship: _____

FOR OFFICE USE ONLY

- Patient refused or declined to sign this written acknowledgement
- Patient could not understand the request to sign written acknowledgement
- Other _____

Employee Signature: _____ Date: _____