Auburn Oral Surgery

3113 Professional Drive Suite 4 Auburn, CA 95603

Acknowledgment of receipt of notice of privacy practices

FOR ALL PATIENTS

PATIENT NAME: _____

1) I acknowledge that I have been offered a copy of this office's Notice of Privacy practice.

Signature: _____ Date: _____

2) I understand that I may be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 90 days.

Signature: _____ Date: _____

3) I understand that photographs may be taken as a record of my care, and may be used for educational purposes in lectures, demonstration to other patients, and marketing efforts to include websites, publications and professional publications. (No if not signed).

Signature: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____Other (Please Specify)

_____