ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Advanced Aesthetic Dentistry's *HIPAA Notice of Privacy Practices*.

I understand that Advanced Aesthetic Dentistry's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Advanced Aesthetic Dentistry's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Advanced Aesthetic Dentistry's *HIPAA Notice of Privacy Practices*, I may contact the Office Manager at (303) 246-0100.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Advanced Aesthetic Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Advanced Aesthetic Dentistry's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask the Office Manager, (noted above), for assistance.

_____ _____

Patient Signature Date

_____ _____

Signature of Parent if Patient is a Minor Print Name of Parent if Patient is a Minor

_____

Relationship to Patient