**Zoe Collier D.D.S.**

Patients Acknowledgement of Receipt of the Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPPAA) requires that we (healthcare providers) give our patients a copy of the Notice of Privacy Practices and make a good faith effort to obtain and acknowledgement of receipt of same. You have the right to refuse to sign this acknowledgement for.

By signing this form I confirm that I have received or have been offered a copy of Dr. Zoe Collier’s Notice of Privacy Practices.

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Written Acknowledgment was not obtained:

* Patient Refused to Sign
* Emergency Situation
* Unable to communicate with patient
* Other