KYLE A. SMITS DDS, PLLC

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

This form will be retained in your dental record.

By my signature below I____,acknowledge that I reviewed a
Print your name here
copy of the Notice of Privacy Practices for Kyle A. Smits DDS, PLLC.

I understand I can request a copy of the Statement of Privacy Practices at any time. I also understand that my dental provider has the right to change the Statement of Privacy Practices; I may contact this office to obtain a current copy of the Statement of Privacy Practices.

____________________________________ ________________________

Signature of patient (or personal representative) Date

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If this acknowledgment is signed by a personal representative on behalf of the patient, or parent on behalf of a child, please complete the following:

Personal Representative's Name:____

Relationship to Patient:____

This acknowledgement and signature also covers the following patients:

____

____

For Office Use Only

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)

____

____________________________________ ________________________

Employee Name Date