

**PROFESSIONAL DENTAL ALLIANCE
ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF INFORMATION AND PRIVACY PRACTICES**

Patient Name: _____

Patient No.: _____

I have been given a copy of Refresh Dental's, a Professional Dental Alliance practice ("**Practice**"), *Notice of Information and Privacy Practices* ("**Notice**"), which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at (765) 698-2492, or by visiting the Practice's web site at www.gorefreshdental.com.

My signature below acknowledges that I have been provided with a copy of the Notice of Information and Privacy Practices:

Signature of Patient or Personal Representative

Date

Print Name

Personal Representative's Title (*e.g., Guardian, Executor of Estate, Health Care Power of Attorney*)

Print Name of Practice Employee Providing/Collecting Notice

Date