HWANG ORTHODONTICS

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of K.C. Hwang, D.D.S., Inc. Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our **Notice of Privacy Practices** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office.

Signature: ___________________________________ Date: _________________________

(parent/patient/conservator/guardian)

Print Name: _________________________________ Date: _________________________

(parent/patient/conservator/guardian)

FOR OFFICE ONLY

INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed only if no signature is obtained. If it is not to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why the acknowledgment was not obtained:

Signature of provider representative: __________________________ Date: _____________

Print name of provider representative: _________________________ Date: _____________

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgment

( ) An emergency situation prevented us from obtaining the acknowledgment

( ) Other (Please Specify)