

Team Dental at River Oaks
16689 River Ridge Blvd.
Woodbridge VA, 22191

**Acknowledgement
For
Receipt of Notice of Privacy Practices**

This form is a receipt noting that you have received the Notice of Privacy Practices.

Name of Patient: _____
(Please Print)

Date of Birth: _____

Address: _____

Date of Service: _____

I have received a copy of the Notice of Privacy Practices.

(Signature)

(Date of Receipt)

If this form is being signed for a minor, an incompetent or otherwise incapacitated person, please fill in the following information:

Legally Authorized Representative's Name:

(Print Name)

Patient is: ___Minor___ Incompetent or Incapacitated

Legal Authority: ___Legal Guardian___ ___Parent of Minor___ ___Health Care Agent___

___Other___

For Office Use Only:

Signature Declined Due to: _____

I personally delivered the Notice of Privacy Practices to the patient listed above. A written Acknowledgement of receipt by the patient was not obtained as noted above.

(Signature of Office Staff Member)

(Date)

Name: _____
(Please Print)

Title: _____