ACKNOWLEDGEMENT OF RECEIPT OF:
NOTICE OF PRIVACY PRACTICES, FINANCIAL AGREEMENT AND OFFICE POLICIES

Purpose: This form is used to document the *Statesboro Pediatric Dentistry's Notice of Privacy Practices* was given to the patient or their personal representative, as required by federal law.
By signing this form, you acknowledge receipt of the Statesboro Pediatric Dentistry *Notice of Privacy Practices as well as Financial Agreement and Office Policies.* Our notice provides information about how we may use and disclose your protected health information. We encourage you to review the notice carefully.

1. I acknowledge receipt of Statesboro Pediatric Dentistry *Notice of Privacy Practices.*
***Initial*_____**

2. I acknowledge that I have read and agree with Financial Agreement regarding Payment, Insurance, Refunds, Missed and Late Appointments.
***Initial*_____**

3. I acknowledge that I have read and agree with Office Policies, regarding guardian/parent's responsibilities, No Photography, No cellphones and no food/no drinks in the treatment/clinical areas, etc.
***Initial*_____**

I have read and understand this authorization. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

_____
Signature of person authorized to sign for patient
Relationship to patient

_____ _____
Print Name *Date*

Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, financial agreement and office policies, but acknowledgement could not be obtained because:
Parent/Guardian refused to sign ☐
Communications barriers prohibited obtaining the acknowledgement ☐
An emergency situation prevented us from obtaining the acknowledgement
Other:

Statesboro Pediatric Dentistry
613 East Grady Street
Statesboro, GA 30458