

*\*Diplomate American Board of Pediatric Dentistry*

**Pediatric Dentistry**  
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**Pediatric Dentistry of Central Florida**  
BISHOP • BERTOT

**Orthodontics**  
John R. Smith, D.D.S., M.S.D.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

### Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Patient/child's name

\_\_\_\_\_  
Please print your name here (parent/guardian)

\_\_\_\_\_  
Signature (parent/guardian)

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (Please provide specific details)

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date