HIPPA PRIVACY
ACKNOWLEDEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, ________________________ (Please print full legal name here) (the "patient" of "patient's legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of Dr. Sinha Kang, D.M.D., P.A. (the "provider"), and have been offered a copy of such policy to keep for my records.

________ (Please initial here) I hereby acknowledge that I have read the Policy and understand its terms and conditions.

________ (Please initial here) I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledge, Provider may still provide to me.

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Signature of Patient Date

Notice of Privacy Practices available upon request and posted up front

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For Office Use Only

I, __________________________________ (Please print full legal name here), acting as

___________________________________ (please print relationship or official position with Provider) for Provider attempted to obtain the written acknowledgement of receipt of the Policy of Provider on ____________________ (Please insert date attempt was made), but acknowledgement could not be obtained because:

_________ (Please initial here) Patient of Patient's legal representative refused to sign.

_________ (Please initial here) Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgment

_________ (Please initial here) Emergency circumstances prevented securing acknowledgment.

_________ (Please initial here) Other (please specify) ____

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Signature of Provider Representative Date