Aesthetic Smiles
Wade Pilling D.M.D.
4795 N Summit Way
Meridian ID 83646

Acknowledgment of Receipt of Notice of Privacy Practices

Name of Patient: _____ _____

I _____, acknowledge that I have read and understand our Notice of Privacy Practices from Wade Pilling D.M.D.

_____, _____
Signature of Patient or Guardian Today's Date

If a personal representative (other than a parent or guardian) signs this authorization on behalf of the individual, complete the following:

_____
Personal representatives name Relationship to individual

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign
___ Communications barrier prohibited obtaining the acknowledgment
___ An emergency situation prevented us from obtaining acknowledgment
___ Other (please specify)

_____
_____