

First: \_\_\_\_\_  
Last: \_\_\_\_\_

**THE PRACTICE OF: GENTLE TOUCH FAMILY DENTISTRY**  
**Acknowledgement of this Practices Privacy Notice**

I acknowledge that I have received, and/or reviewed the notice of the Privacy Practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of the Privacy Practices is posted in the office where I can review it if desired.

Patient or Parent if Patient is under 18 years of age: \_\_\_\_\_

Date: \_\_\_\_\_

**DOCUMENT OF "GOOD FAITH EFFORT"**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

The patient presented for treatment on this date, and was provided the Practices Privacy Notice. A Good Faith was made to obtain written acknowledgement of receipt. A written acknowledgement was not obtained because:

\_\_\_\_\_ Patient refused to sign, with the reason \_\_\_\_\_

\_\_\_\_\_ Patient is unable to sign due to \_\_\_\_\_

\_\_\_\_\_ There was a medical emergency preventing timely signature, and an attempt will be made to obtain acknowledgement later.

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Signature of employee completing this form.