J. TERRELL LEWIS, D.M.D.
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P.O. BOX 998
PH (843)558-5013
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name & Address_____

_____

_____

I have received, or been offered, a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

Relationship to Patient_____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because of the following reason(s):

___ An emergency existed & a signature was not possible at the time.

___ The individual refused to sign.

___ A copy was mailed with a request for signature by return mail.

___ Unable to communicate with the patient for the following reason:
_____

___ Other_____
_____

Prepared By_____

Signature_____

Date_____