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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

“You May Refuse To Sign This Acknowledgement”

I have reviewed a copy of this office’s Notice of Privacy Practices. I understand a copy of the Privacy Practice is available to me upon request.

(Please Print Patient’s Name)

(Patient’s signature – Parent or Guardian if under age 18)

(Date)

FOR OFFICE USE ONLY

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

- ___ Individual refused to sign
 - ___ Communications barriers prohibited obtaining the acknowledgement
 - ___ An emergency situation prevented us from obtaining acknowledgement
 - ___ Other (Please Specify)
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