Southside Endodontics, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have reviewed and/or received a copy of this office's Notice of Privacy Practices.

_____

Signature of Patient or Legal designate 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)

Physician/Patient Termination Policy for No Show

Our office will dismiss a patient due to failure to show for two appointments. A termination letter will be mailed to the patient. Effective within 30 days from the date of the letter, the patient will no longer be eligible for care in our practice.

_____

Signature of Patient or Legal designate Date

_____

Signature of Doctor Date