

# ***Arnold Dentistry, PA***

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## **HIPAA ACKNOWLEDGEMENT OF RECEIPT**

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF ARNOLD DENTISTRY, PA NOTICE OF PRIVACY PRACTICES.**

**PATIENT NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT: SELF OR PARENT/GUARDIAN**

**DATE:** \_\_\_\_\_

***Any reminder messages for upcoming appointments will be left on the home phone and cell phone voicemails unless otherwise indicated below.***

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