Acknowledgment of Receipt of the Notice of Privacy Practices
for the office of
Appalachian Dental Associates, PC

I, ____ have received a copy of the Notice of Privacy Practices from the office of Appalachian Dental Associates, PC, either for myself or my child, who is the patient. I understand that this information can & will be used to:

- Conduct, plan & direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations.

_______________________________________ _________________________

Signature **Date**

I, ____ give permission to Appalachian Dental Associates, P.C. to contact me regarding appointments, etc. which may include leaving a message, whether it be with a family member or on an answering machine. I also authorize the release of financial and/or treatment information to be released to:

____

(Name) ***(Relationship)***

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(Name) ***(Relationship)***

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(Name) ***(Relationship)***

_______________________________________ _________________________

Signature **Date**