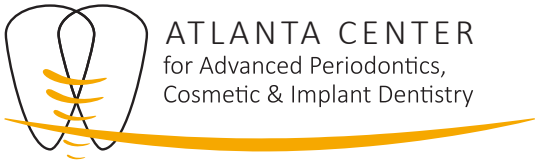

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient: _____ DOB: _____

By my signature below, I acknowledge that I have received either a paper or an electronic copy of the **HIPAA NOTICE OF PRIVACY PRACTICES** for **ATLANTA CENTER FOR ADVANCED PERIODONTICS, COSMETIC & IMPLANT DENTISTRY-MIDTOWN, LLC** (the "Practice"). I also understand that I am entitled to receive a paper copy of the HIPAA **NOTICE OF PRIVACY PRACTICES** upon request, even if I have previously agreed to receive only an electronic copy.

Signature: _____ Date: _____

If applicable:
Representative Name: _____ Date: _____

Relationship to patient: _____

PERMISSION TO DISCUSS TREATMENT OR BILLING INFORMATION

By my signature below, I authorize the Practice to discuss my treatment and/or billing information with:

_____

Signature: _____ Date: _____

If applicable:
Representative Name: _____ Date: _____

Relationship to patient: _____

FOR OFFICE USE ONLY: *Only if the acknowledgment above is not signed by the patient or the patient's representative.*

A good faith effort was made to obtain a written **ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES**, but could not be obtained because *(please check as appropriate)*:

_____ Refusal by patient or patient's representative.
_____ A communication barrier prevented obtaining a signature.
_____ An emergency situation prevented obtaining a signature.
_____ Other: _____.

Staff Member: _____ Date: _____