Notice of Privacy Practices Acknowledgement
Learman Dental

4141 Shrestha Dr.
Bay City, MI 48706

117 N. Forest St.
Standish, MI 48658

The undersigned Patient or Legally Authorized Representative (Agent) of the Patient acknowledges that he or she personally received or was offered a copy of Dr. Learman's Notice of Privacy Practices on the date indicated below.

Patient Name ____ DOB: _______________________

Signature: ____ Date: _______________________
Patient Signature *(if child signature of parent/guardian)*

You may discuss my dental information with the following people:

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____

____

May we leave messages on:

___ Home phone

___ Cell phone

___ Work

___ None

Please check what types of messages are allowed to be left:

_____ Scheduled appointment reminder

_____ Appointment reminder postcards in mail

_____ Reminder to take medication needed for appointment

_____ Reminder to bring appliances

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date__________ Staff Signature ____

Reason: ____

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