THANE B. ANDERSON DDS
Dentistry For Today's Family

1520 Vernon Street, Stoughton WI 53589
608.873.3213

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

The Patient:

Name: _____

Address: _____

Telephone: _____ email: _____

Acknowledgement of Receipt of Privacy Practices Notice:

I, _____, acknowledge that I was offered a Notice of Privacy Practices from Thane B. Anderson, DDS, LLC.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Good Faith Effort to Obtain Acknowledgement of Receipt:

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

Describe the reason why the individual would not sign this form: _____

_____

Staff Signature:
I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____