PRILL DENTAL

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PATIENT ACKNOWLEDGEMENT

I, ______________________________, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

I, ______________________________, hereby decline receipt of a copy of the Notice of Privacy Practices.

______________________________ ______________
PATIENT'S SIGNATURE DATE

______________________________ ______________
SIGNATURE OF PARENT OR PATIENT REPRESENTATIVE DATE

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DESCRIPTION OF LEGAL AUTHORITY TO ACT ON BEHALF OF PATIENT

820 NORTH 30TH STREET BILLINGS. MT 59101 TEL: 406.252.1533 FAX: 406.252.1168