Patient Name: _____ Patient Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Lisa Konz DDS, PC's Notice of Privacy Practices.

_____ _____
Signature Date

Relationship to Patient: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Home # _____
May we leave a detailed message at home? Yes ____ No _____

Work # _____
May we leave a detailed message at work? Yes ____ No _____

Cell # _____
May we leave a detailed message on your cell? Yes ____ No _____

_____ _____
Signature Date

Relationship to Patient: _____

☐ I decline to sign the Acknowledgement.

OFFICE USE ONLY:
The office was unable to obtain a signed Acknowledgement form from the above patient for the following reasons: