The Practice of : **Neil L. Matthews D.D.S.,M.S.**
Acknowledgement of Receipt of this Practices Privacy Notice

I acknowledge that I have received, and/or reviewed the notice of the Privacy practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of the practices Privacy Practices is posted in the office where I can review it if desired.

_____ _____
Patient or Patient Representative or Parent of patients under age 18 Date

(If patient representative signs above, please describe the relationship to the patient.)

Documentation of "Good Faith Effort"

Patient Name:_____ Date:_____

The patient presented for treatment on this date, and was provided the practices Privacy Notice. A good faith effort was made to obtain written acknowledgement of receipt. A written acknowledgement was not obtained because:

_____ Patient refused to sign, with the reason _____

_____Patient is unable to sign due to : _____

_____There was medical emergency preventing timely signature, and an attempt will be made to obtain acknowledgement later

_____Other: _____

Signature of employee completing this form