

INDIANA FAMILY DENTISTRY, L.L.C.
WILLIAM C. HINE, D.D.S.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICE**

You May Refuse To Sign This Acknowledgement*

I, _____, have received a copy of the
(Name of Patient/Parent)

Notice of Privacy Practices, for Indiana Family Dentistry, L.L.C.

(Please print your name or names of your minor children)

Date

(Patient/Parents Signature)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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