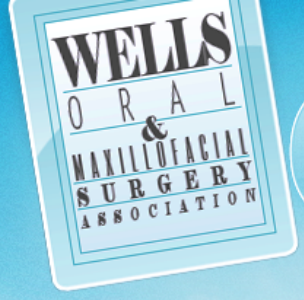


CELEBRATING OVER 30 YEARS OF CARE


# WELLS ORAL AND MAXILLOFACIAL SURGERY ASSOCIATION

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgment*

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Wells Oral and Maxillofacial Surgery Association this _____ day of _____, 20____. A copy of this signed and dated Acknowledgement shall be as effective as the original.

_____
Please print your name

_____
Please sign your name

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority

_____

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Nicole Wells or her designee.

**OFFICE USE ONLY**

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment

_____

I could not communicate with the patient

_____

The patient refused to sign

_____

The patient was unable to sign because

_____

Other (please describe)

_____

_____
Date and signature of privacy officer or designee