**ACKNOWLEDGEMENT OF RECEIPT OF
HIPPA - PRIVACY PRACTICES NOTICE**

Dr. Scott S. Johnson D.D.S. -- 7325 South Pierce Street, Suite 104 -- Littleton, Colorado 80128

The Patient

Name: ____ Date of Birth: ___________________________

Acknowledgement Receipt of Privacy Practice Notice.

I, ____, Acknowledge that I have received and read a Notice of Privacy Practices from the above-named practice.

If a patient is a minor please complete the following:

Minor's Full Name: ___________________________________ Date of Birth: ______________________

Parent / Guardian Name: ____

SIGNATURE: I agree that the above information is correct.

Signature: ____ Date: ___________________________________

Good Faith Effort to Obtain Acknowledgement of Receipt.

Please state reason below if not signing **HIPPA** form: