Smile Design

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Acknowledgment of Receipt of Notice of Privacy Practices

Patient name: ________________________________

I have been offered to view and/or received a copy of Smile Design/Marc L. Susman, D.D.S.' Notice of Privacy Practices.

I understand that my protected heath information can and will be used for the purpose of payment from both myself, responsible party, insurance copy and third-party collection agencies if needed. I also understand that my information will be released to communicate with referring specialist about my treatment and/or insurance information.

I understand that I may request a copy of the Notice of Privacy Practices at any time.

I consent for the following people to have access to my protected health information for the purpose of viewing/making appointments, going over treatment plans and financial obligations and/or account balances.

Name: _____________________________ Relationship: ______________

Name: _____________________________ Relationship: ______________

Name: _____________________________ Relationship: ______________

I may refuse to sign this acknowledgement.

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Patient Signature (parent/guardian if minor) **Date**