Plymouth Greene Dental is required by the Privacy Standards of the Health Insurance portability and Accountability Act of 1996 to provide each patient and his/her representative a copy of our Notice of Privacy Practices. We are also required to obtain a signed acknowledgement of receipt from each patient and his/her legal representative. We appreciate your cooperation in signing below to fulfill this requirement.

Any questions Dr. Elena Kachur would answer these for you.

I_____, acknowledge receipt of the Plymouth Greene Dental

(PRINT YOUR NAME)

Notice of Privacy Practices on behalf of _____

(PRINT YOUR NAME)

(SIGNATURE) (DATE)