



Mission Dental Implant Center
2600 Crown Valley Parkway, Suite 425
Mission Viejo, CA 92691

ACKNOWLEDGMENT

This form acknowledges your receipt of the HIPAA Notice of Privacy Practices, or our good faith effort to obtain that acknowledgment.

Patients Name (Print): _____

Patients Signature: _____

Date: _____

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

FOR OFFICE USE ONLY BELOW THIS LINE

PLEASE SPECIFY THE REASON THE PATIENT CHOSE NOT TO SIGN THE
ACKNOWLEDGMENT OF RECEIPT OF THE HIPAA NOTICE OF PRIVACY
PRACTICES:

Employee Signature: _____ Date: _____

Title: _____