

**PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF  
PRIVACY RULES**

I, \_\_\_\_\_, have received a copy of the  
Notice of the privacy Practices of Smiles On Cass.

I decline to sign the Acknowledgement.

OPTING OUT:

I do NOT want appointment reminder messages left on my home answering system.  
*I understand that the office may charge me should I fail to keep my appointment.*

I do NOT want appointment reminder messages left on my business answering  
system. *I understand that the office may charge me should I fail to keep my appointment.*

I do NOT wish my protected health care information to be released to the following

persons: \_\_\_\_\_  
Name and address

\_\_\_\_\_  
Please print your name:

\_\_\_\_\_  
Signature

OFFICE USE:

**The office was unable to obtain a signed Acknowledgement form from the above patient for  
the following reasons:**