ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I have been given a copy of Berks Endodontics, Ltd. Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient or Personal Representative *Date*

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

_____

_____

COMPLETED BY:

_____ _____

Signature of Patient or Personal Representative *Date*

_____

Print Name

1150 Berkshire Blvd, Suite #120, Wyomissing PA 19610
Phone: 610-376-1536 | Fax: 610-376-4241

Berks Endodontics
SCOTT BRAM, D.M.D. • BRIAN FREY, D.M.D.