Sona Georgian D.D.S. Inc
32144 Agoura Road Suite 213
Westlake Village, CA 91361
(818)991-4664 Fax (818)991-4665

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

PATIENT

NAME _____

ADDRESS_____

TELEPHONE NUMBER_____

E-MAIL _____

SS#_____

I_____, ACKNOWLEDGE THAT I RECEIVED A NOTICE OF PRIVACY PRACTICES FORM SONA GEORGIAN D.D.S. INC

SIGNATURE_____ DATE_____

IF A PERSONAL REPRESENTATIVE SIGNS THIS AUTHORIZATION OF BEHALF OF THE INDUVIDUAL, COMPLETE THE FOLLOWING

PERSONAL REPRESENTAIVE'S NAME_____

RELATIONSHIP TO INDIVUDIAL _____

GOOD EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT

DESCRIBE YOUR GOOD FAITH EFFORT TO OBTAIN THE INDIVIDUAL'S SIGNATURE ON THIS FORM
_____

_____

DESCRIBE THE REASON WHY THE INDIVIDAUAL WOULD NOT SIGN THIS FORM:
_____

_____

ATTEST THAT THE ABOVE INFROMATION IS CORRECT

SIGNATURE: _____ DATE _____

PRINT NAME: _____ DATE _____