Hampton Dental Associates

5323 W. Hampton Avenue
Milwaukee WI 53218

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

As required by the privacy provisions of the Health Insurance Portability Accountability Act (HIPPA), you are being asked to sign the acknowledgment below. Your signature indicates that you have RECEIVED a copy of Hampton Dental's Notice Of Privacy Practices. It does NOT mean that you have read or understand the notice.

If you have any questions or concern regarding this notice or Hampton Dental's Privacy Practices, please contact our Privacy Officer at 414-464-9021

WRITTEN ACKNOWLEDGMENT

OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received from Hampton Dental Associates a copy of its Notice of Privacy Practices.

Please Print Patient's Name:_______________________________________

Patient's Date Of Birth____

Signature:____

Date:_______________________

Relationship To The Patient:______________________________________