

**ACKNOWLEDGMENT FORM**

**THIS FORM IS USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF  
OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR  
GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.**

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**NAME OF PATIENT (PLEASE PRINT)**

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**SIGNATURE OF PATIENT**

**DATE**

**YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT**

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**BELOW THIS LINE FOR OFFICE USE ONLY**

**PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN  
THE ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY**

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**SIGNATURE**

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**Title**

**Date**

**MICHAEL T. PRUDHOMME D.D.S. AND ASSOCIATES**