

**KYLE A. SMITS DDS, PLLC  
PAUL K. SMITS DDS, PS**

**ACKNOWLEDGEMENT OF REVIEW OF  
NOTICE OF PRIVACY PRACTICES**

*This form will be retained in your dental record.*

By my signature below I \_\_\_\_\_, acknowledge that I reviewed a  
Print your name here  
copy of the Notice of Privacy Practices for Kyle A. Smits DDS and Paul K. Smits DDS, PS.

I understand I can request a copy of the Statement of Privacy Practices at any time. I also understand that my dental provider has the right to change the Statement of Privacy Practices; I may contact this office to obtain a current copy of the Statement of Privacy Practices.

\_\_\_\_\_  
Signature of patient (or personal representative)

\_\_\_\_\_  
Date

\*\*\*\*\*

**If this acknowledgment is signed by a personal representative on behalf of the patient, or parent on behalf of a child, please complete the following:**

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

This acknowledgement and signature also covers the following patients:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Office Use Only**

Attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date