ROBERT A. ZAMBROWSKI, D.M.D., M.A.G.D.

MICHAEL A. ZAMBROWSKI, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, have received or been offered a copy of Dr. Robert and Dr. Michael Zambrowski's Notice of Privacy Practices.

Print Your Name: _____.

Signature of Patient or Representative:_____ Date:_____

Relationship of Representative /authority to act on behalf of the Patient:_____

_____

INFORMATION DISCLOSURE

Please circle: YES or NO

May we discuss details regarding your care, treatment, billing/insurance information, and appointment information with someone else, other than you? For example, your husband/wife, parent, child, friend, etc. If yes, you must list the name and relationship of each individual below.

NAME (Please Print)	RELATIONSHIP
1._____	_____
2._____	_____
3._____	_____

Print Your Name:_____

Signature of Patient or Representative:_____ Date:_____

Relationship of Representative / authority to act on behalf of the Patient:_____

_____

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_____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign
_____ Communication barrier prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgment
_____ Other (Please Specify)

_____