



**Fox Valley Dental Care, LLC**

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

**I acknowledge that I have received a copy of this office's Notice of Privacy Practices.**

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Please print name

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Signature

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Date

### For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Privacy Notice from this patient, but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We were unable to communicate with the patient.
- Other: \_\_\_\_\_

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Employee Signature

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Date