

**PEDIATRIC DENTISTRY**  
**JEFFREY P. HEILIG, D.M.D., P.A.**  
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Weston, FL 33326

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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

\*You May Refuse to Sign This Acknowledgment\*

**I have received a copy of this office's currently effective Notice of Privacy Practices.**

A copy of this signed, dated Acknowledgement shall be as effective as the original.

\_\_\_\_\_  
Print First and Last Name of Parent or Legal Guardian

\_\_\_\_\_  
Signature of Parent or Legal Guardian

If you are the legal representative of the **Patient**:

\_\_\_\_\_  
Print First and Last Name of **Patient** and circle your Relationship/Authority      Parent      Legal Guardian

\_\_\_\_\_  
Date

Thank you and if you have any questions about this form or the Notice,  
please contact our privacy officer, **Jeffrey P. Heilig, D.M.D.**

\_\_\_\_\_  
**Office Use Only**

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment \_\_\_\_\_  
I could not communicate with the patient \_\_\_\_\_  
The patient refused to sign \_\_\_\_\_  
The patient was unable to sign because \_\_\_\_\_  
Other (please describe) \_\_\_\_\_

\_\_\_\_\_  
Signature of privacy officer