

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I understand that Travis P. Phillips, DMD, LLC may use or disclose my health information for treatment purposes, in order to receive payment, and for other healthcare operations. I have been given a copy of the notice of privacy practices that describes how my health information is used and shared. I understand that this office has the right to change this notice at any time. I may obtain a current copy by contacting the office during business hours.

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

Signature of Patient or Legal Representative

Date

If signed by legal representative, relationship to patient:_____