ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF ANDREW K. ARMBRISTER D.D.S, PLLC

I,_____ HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM THE OFFICE OF ANDREW K. ARMBRISTER, D.D.S, PLLC EITHER FOR MYSELF OR MY CHILD , WHO IS THE PATIENT. I DO UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- **CONDUCT, PLAN & DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY OR INDIRECTLY**
- **OBTAIN PAYMENT FROM THIRD- PARTY PAYERS**
- **CONDUCT NORMAL HEALTHCARE OPERATIONS**

_____

SIGNATURE DATE

I, _____GIVE PERMISSION TO ANDREW K. ARMBRISTER, D.D.S, PLLC TO CONTACT ME REGARDING MY APPOINTMENTS, ETC., WHICH MAY INCLUDE LEAVING A MESSAGE, WHETHER IT MAY BE WITH A FAMILY MEMBER OR ON AN ANSWERING MACHINE.

_____

SIGNATURE DATE