JAMES F. KOTSIANAS, DDS
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

I, _____, have reviewed a copy of James F. Kotsianas, DDS's Notice of Privacy Practices.

_____
Patient Name

_____
Signature Relationship to Patient

_____
Date

I give permission to Dr. James Kotsianas and staff members to leave messages regarding my dental appointment, and/or to discuss my dental care (including treatment, payments, insurance information) in the following manner.

- o May ONLY leave information with me and not anyone else.
- o May leave general questions/information/account information with my family *

* If option checked above, please list name of individual we may give information to:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____