

Dr. Connie Argüello D.D.S.  
11358 Miramar Parkway  
Miramar, FL 33025  
954-442-0006

**Notice of Privacy Practice Acknowledgement**

This form is used to obtain acknowledgement of receipt of our notice of privacy practices or to document our good faith effort that acknowledgement.

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Name of Patient (Please Print)

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Signature of Patient or Parent/Guardian

Date

**You may to refuse to sign this acknowledgement**

**\*\*Below this line for office use only**

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Please specify the exact reason why patient chose not to sign the Acknowledge of receipt of notice of privacy.

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Signature

Title

Date

All forms are for educational use only and do not constitute legal advice. All forms are subjects to change in the federal law and applicable state law. Seek legal advice before use.