West Michigan Periodontics
Brian Cilla, D.D.S., M.S.

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

Name: _____ Date: _____

Signature: _____

Or Personal Representative: _____

Authority of Personal Representative to sign for patient:

___Parent ____Guardian ____Power of attorney ____Other: _____

Please list other parties with whom West Michigan Periodontics can discuss your health and financial information with.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)
