



Katherine K. Yi, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received the Notice of Privacy Practices from the office Complete Smile.

Name

Signature

Date

Do we have your permission to send your information pertaining to our services by mail? Yes___ No___

Do we have your permissions to remind you by telephone or email of any appointment at home or at work? Yes___ No___

This acknowledgement page should be retained in the patient file. If acknowledgement could not be obtained from patient, the reason must be documented below.

302 Satellite Blvd NE #216 Suwanee, GA 30024
Phone: 678.541.6020 Fax: 678.541.6023