Jan T. Bagwell, D.D.S.
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(318) 665-4423

Notice of Privacy Practices
Patient Acknowledgement

_____ I,(patient name) ✳ ______________________________, acknowledge receipt of this **Notice of Privacy Practices**.

_____ I,______________________________, certify that I have made a good faith effort to obtain written acknowledgement of receipt of this **Notice of Privacy Practices**, from patient ______________________________ but the acknowledgement was not obtained because:

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____.

Signature: ✳ ______________________________ Date: ✳ ____________

Relationship to patient (if signed by a personal representative of patient)____________

This document must remain in the patient's chart at all times.

This document must be retained for the longer of 6 years from the date of its creation or when it was last in effect.