ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Patient's Name_____ Patient's Date of Birth_____

I, _____, (Parent, Guardian, or Patient if over age 18) acknowledge that I have received a copy of the Notice of Privacy Practices from Nth Degree Orthodontics. I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I have read this form and had the opportunity to ask questions.

_____ _____

Signature of Patient or Authorized Person Date

(Required if patient is a minor or an adult unable to sign form)