

LAUREN M. SIMON, DDS, PLLC
DENTISTRY

DBA: NOKESVILLE FAMILY

Patient's Acknowledgement of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of LAUREN M. SIMON, DDS, PLLC's Notice of Privacy Practices.

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving dental services.

Signature:

Printed Name:

Date: _____