SCHEELE ORTHODONTICS, INC.

Practice limited to Orthodontics

ANGELA SCHEELE, D.D.S

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I_____, have received a copy of this office Notice of Privacy Practices.

_____

Please Print Name (Parent or guardian)

_____

Signature date

_____

Name of Child

Please list names, phone number and relationship to patient that protected health information can be released to:

Name	Relationship	Phone Number

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)