# NEW SMILE FAMILY DENTISTRY
# MATTHEW REITH DDS PLLC
## 125-B South Bloomington
## Lowell, Arkansas 72745
## 479-770-5000

**ACKNOWLEDGEMENT OF RECEIPT OF**
**NOTICE OF PRIVACY PRACTICES**

Patient Name: _____ Date: _____

***I may refuse to sign this acknowledgement.***

**I have been offered and / or received a copy of Dr Matthew Reith's Notice of Privacy Practices.**

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

**Expiration -- 3 Years from Initial Signature; Insurance Change; Patient reaches age of 18**

I consent for the office of Dr Matthew Reith to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone

_____ /_____ / _____

_____ /_____ / _____

Signature: _____

□ Patient □ Parent □ Guardian / Other