

**DAVID G. BLINKY, D.M.D., P.C.**

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

**HIPAA**

**Personal or dental information will only be given to patient's specialist or dental insurance company.**

I, \_\_\_\_\_, understand this office's Notice of Privacy Practices.  
(Please Print PATIENT Name)

\_\_\_\_\_  
(Signature-Patient, Parent or Guardian)

\_\_\_\_\_  
(Date)

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**For Office Use Only**

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**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**
- Communications barriers prohibited obtaining the acknowledgement**
- An emergency situation prevented us from acknowledgement**
- Other (Please Specify)**