



Susanna N. Zilberman, D.D.S., P.C.

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. **By signing below I consent for the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice.** I also understand that I have the rights not sign this agreement.

Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

If we are unable to get your acknowledgement then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

Staff Name: _____

Signature: _____

Date: _____