

**BRAD JONES DDS**  
**2662 East Joyce Boulevard, Suite 1**  
**Fayetteville, Arkansas 72703**  
**479-521-3107**

**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 Brad Jones 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 Brad Jones to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/

\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/

\_\_\_\_\_

Signature: \_\_\_\_\_

Patient

Parent

Guardian / Other