



FLOSS AND SMILE, P.C

1438 Duke st  
Alexandria, VA 22314  
703-212-0602 tel  
703-212-0607 fax

**PATIENT'S ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, acknowledge that I  
Received and reviewed the office privacy policy for Floss and Smile, P. C.

\_\_\_\_\_  
Patient / Responsible Party Signature

\_\_\_\_\_  
Date

In case you do not agree to sign this form our office must indicate why you  
declined to do so.

Reason for patient's refusal:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OFFICE USE ONLY

\_\_\_\_\_  
Privacy Director's Signature

\_\_\_\_\_  
Date