



McCARTHY  
DENTISTRY

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**Family, Cosmetic and Implant Dentistry**

### **Acknowledgement of Receipt of Notice of Privacy Practices**

The undersigned patient or legally authorized representative ("agent") of the patient acknowledges that he or she personally received a copy of the notice of privacy policies on the date indicated below.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_