A. PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____

Print Patient's Name Date

I, _____acknowledge that I have received a
(Signature of Patient or Parent or Legal Guardian)

copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF

PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of my
(Signature of Patient or Parent or Legal Guardian)

personal health information by your office for Treatment, Billing/Payment and Healthcare

Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

B. PATIENT CONSENT TO RECEIVE MAIL AND /OR TELEPHONE MESSAGES

_____

Print Patient's Name

Email Address: _____

Best Phone Number to reach: _____

Do we have your permission to:

Send a recall appointment reminder to your home? Y_____ N_____
Contact you or leave appointment, billing or dental information
On your answering machine/Telephone / voice mail/e-mail: Y_____ N_____
I give permission to share appointment, billing or dental information with the person named below:

Name: _____

_____ _____

Signature of Patient / Parent or Legal Guardian Date