HIPAA Receipt/ Consent

____
(Last Name) *please print* (First Name) (M.I)

I agree that the practice may communicate with me electronically at the following address:

____
(E-mail Address) *please print*

I consent to receive call and/ or text messages related to my protected dental services at the phone number(s) below, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

____
Phone Number

Do we have permission to:

Send appointment reminders to your home? Yes_______ No_______

Leave appointment, billing or dental information on your answering machine/voice-mail/e-mail? Yes_______ No_______

I give permission to share my appointment, billing or dental information with the person named below:

Name: ________________________________

______________________________________ _____________________
Signature of Patient, Parent or Guardian Date

If signed by other than patient, please specify relationship to patient: _______________________

Acknowledgment of Receipt of Notice of Privacy practices

I, _________________________, have received a copy of this office's Notice of Privacy Practices.

_______________________________________ ____________________
Signature of Patient, Parent or Guardian Date

If signed by other than patient, please specify relationship to patient: ________________________________