PATIENT ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment but, in refusing we *will not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Tennyson Lake Dental.

Please print your name:_____ Please sign your name:_____

Please list any other parties who can have access to your dental information: (This includes step parents, grandparents, and any caretakers who can have access to this patient's records.)

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY DENTAL APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA:

□ CELL □ TEXT □ HOME □ EMAIL □ WORK □ MAIL/POSTCARD

I AUTHORIZE INFORMATION ABOUT MY DENTAL HEALTH BE CONVEYED VIA:

□ CELL □ TEXT □ HOME □ EMAIL □ WORK □ MAIL/POSTCARD

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS OR NEW DENTAL INFORMATION VIA:

□ CELL □ TEXT □ HOME □ EMAIL □ WORK □ MAIL/POSTCARD

OFFICE USE ONLY:

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

□ It was emergency treatment □ I could not communicate with the patient □ The patient refused to sign

□The patient was unable to sign because_____

□ Other, please describe:_____

Signature of Privacy Officer:_____