

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement 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 Brookdale Dental Care. A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please **print** your name

Please **sign** your name

Date

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

(This includes step parents, grandparents, and any care takers 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, & BILLING INFORMATION** VIA:

- Cell phone/text confirmation
- Home phone confirmation
- Work confirmation
- Email confirmation

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** TO BE CONVEYED VIA:

- Message on cell phone
- Message on home phone
- Message on work phone
- Text message
- Email message

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on the 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 _____

Other: _____