Cosmetic & Family Dentistry

EXCELLENT DENTISTRY
EXTRAORDINARY SMILES

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE RECEIPT

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

In the event a family member or caregiver attends my office visits, and is in the exam room at the time of my evaluation and/or treatment, I give Cosmetic & Family Dentistry, it's providers and employees my permission to discuss freely my condition, treatment or diagnosis with the person(s) present.

(CHECK ONE) ❑ YES ❑ NO

Home Phone: _____ May we leave a detailed message? ❑ YES ❑ NO

Work Phone: _____ May we leave a detailed message? ❑ YES ❑ NO

Cell Phone: _____ May we leave a detailed message? ❑ YES ❑ NO

MAY WE CALL YOUR NAME OUT LOUD IN OUR LOBBY? ❑ YES ❑ NO

With whom may we discuss information about your care, treatment and/or diagnosis?

_____ Relationship: _____

_____ Relationship: _____

Whom shall we contact in case of emergency?

Name: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

By signing below, I acknowledge that I am aware of this facility's Notice of Privacy Practices is posted for my convenience.

Patient Signature: _____ Date: _____

Printed Name: _____

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