ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete copy of the Clinic's Notice of Privacy Practices is posted in the facility. You are welcome to take a copy of the Practices. By signing below you acknowledge that you have viewed a copy of our Notice of Privacy Practices.

X____

Signature of Patient or Parent if Patient is a Minor or Incompetent **Date**

> In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

________ **BY CHECKING HERE, I CONSENT TO THE FOLLOWING:** Nowlin Dental Clinic, PLLC or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. Nowlin Dental Clinic, PLLC may also contact me to check on my progress after treatment. Nowlin Dental Clinic, PLLC may:

_____ Call and Text me   _____ Only call me   _____ Only text me

These are the phone numbers at which Nowlin Dental Clinic can contact me and leave a detailed message:

__(_____)________________________ Home Work Cell

__(______)________________________ Home Work Cell

__(______)________________________ Home Work Cell

IF YOU ALLOW US TO TEXT APPOINTMENT CONFIRMATIONS TO YOU, WE WILL AUTOMATICALLY SEND YOU CONFIRMATION TEXT MESSAGES AT 1 WEEK, 2 DAYS, AND 1 HOUR BEFORE YOUR APPOINTMENT. IF YOU PREFER FEWER TEXT CONFIRMATIONS PLEASE ADVISE OUR FRONT OFFICE STAFF.

______ **BY CHECKING HERE, I GIVE CONSENT TO BE CONTACTED BY EMAIL FOR THE FOLLOWING:** appointment and treatment information and for our newsletters, surveys, promotions, etc. **EMAIL ADDRESS:** ____

I allow you to give my clinical information to or answer questions from (*check all that apply)*:

- ☐ Spouse; Name ____
- ☐ Parent; Name ____
- ☐ Child; Name ____
- ☐ Other (specify): ____
- ☐ None

X_____________________________________   ____________________
Print Name   Patient Birth Date

X_____________________________________   ____________________
Patient/Guardian Signature   Date