ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
Print Name

_____ _____
(Signature) (Date)

I, _____, consent to the use of any photographs, intraoral or extraoral, taken for educational purposes.

_____ _____
(Signature) (Date)

May we phone, email or send a text to you to confirm appointments? □ YES □ NO
May we leave a message on your answering machine at home or on your cell phone? □ YES □ NO
May we discuss your health or billing with any member of your family? □ YES □ NO

- IF YES, PLEASE NAME FAMILY MEMBERS & RELATIONSHIP:

NAME	RELATIONSHIP