Patient Consent to receive Mail and/or Telephone Messages

Please Print (Last Name) (First Name) (M.L)

Do we have your permission to?

Send a recall appointment reminder to your home? Y ___ N___

Leave the following information on your home answering machine/voice mail:

Appointment information Y ____N_____

Billing information Y ____ N_____

Dental/Medical information Y____ N_____

Leave the following information on your work answering machine/voice mail:

Appointment information Y ____N_____

Billing information Y____ N_____

Dental/Medical information Y____ N_____

I give permission to share appointment information with the person named below:

Name: _____

I give permission to share dental/medical information with the person named below:

Name: _____

I give permission to share billing information with the person named below:

Name: _____

_____ _____

Signature of Patient Date

DAVID A FIELDS D.D.S.,P.A.

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.

_____

Please Print Name

_____

Signature

_____

Date

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

_____

_____

_____