PRIVACY PRACTICES ACKNOWLEDGEMENT AND RECEIPT

You May Refuse to Sign this Acknowledgement

I understand that I have certain right to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected heath information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I, _____, have received a copy of Kennedy Dental Group Notice of Privacy Practices.

PATIENT SIGNATURE: _____

DATE: _____

PERMISSION TO RELEASE PRIVATE HEALTH INFORMATION

☐ PLEASE DON'T SHARE MY DENTAL INFORMATION

If you check this box we do not need additional information, only your signature.

I give permission for the following people to have access to my private health and account information:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

I give permission to employees and staff of Kennedy Dental Group to share my dental care and/or health history including records, diagnosis, recommended treatment, dates of any treatment recommended or rendered and costs of services and payment received associated with them. I acknowledge that this permission is optional and can be revoked by me in writing at any point in time. I also understand that this permission is in addition to permissions granted by signing Kennedy Dental Group Privacy Practices and shall remain in effect until revoked.

PATIENT SIGNATURE: _____

DATE: _____

PATIENT CONSENT FOR ELECTRONIC COMMUNICATION

Our office would like to communicate with you electronically via email. By utilizing our practice's electronic services, you agree that Kennedy Dental Group may communicate with you regarding information about your invoice, accounts payable, insurance, dental treatment any dental visits. We do NOT give your email address to marketing companies.

I, _____, in the presence of my dentist or the dental practice's privacy representative, agree that the practice may electronically communicate with me at the following email address:

PATIENT SIGNATURE: _____

DATE: _____

☐ **DECLINE SERVICE**

OFFICE AND FINANCIAL POLICIES

I have read and understand the Office and Financial Policies. I have had the opportunity to ask any questions and I agree to comply with the policies. I certify to the best of my knowledge that all information I have been provided is accurate and true. By signing this agreement, you agree to pay for any costs we estimate due to us at the time of services.

PATIENT SIGNATURE: _____

DATE: _____