## Barbara J. Utermark, D.M.D., P.C.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assurance and dental chart reviews.

We ask that you please read the current Notice of Privacy Practices for PHI located in the front office

**Acknowledgement of Receipt of Notice of Privacy Practices.**

Print Patient's Name:_____

Patient/Parent/Guardian Signature:_____

Date:_____

**Please list below name, relationship, and phone number of individuals, including, but not limited to, other Dental Professionals, that we may communicate with regarding this patient's PHI (Protected Health Information):**

| **Name** | **Relationship** | **Telephone Number** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**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) _____

*Please initial by each form of communication by which we can contact the patient/parent*

***IF THERE IS A METHOD BY WHICH YOU DO NOT WISH TO BE CONTACTED, PLEASE WRITE "DO NOT CONTACT" IN THE BLANK***

_____ Barbara J. Utermark, D.M.D., P.C. may **call** my home at the following number and leave the appointment date and time on my telephone answering machine, voicemail, or with whomever answers my phone if I am not available. I understand that other individuals may have access to the information left by this method. I understand that no other information will be provided in granting permission to leave the date and time.

**Telephone number(s) on which messages can be left: _____**

_____ Barbara J. Utermark, D.M.D., P.C. may **email** my home or other email addresses any information that will assist Barbara J. Utermark, D.M.D., P.C. with the treatment, payment, and health care operations for the patient. This can include appointment reminders, statements, insurance information, and any information concerning the patient's clinical care.

**Email address to which information can be sent: _____**

_____ Barbara J. Utermark, D.M.D., P.C. may send a **text message** to my cellular phone regarding appointment reminders, cancellations, or time changes. This form of communication will be for the use of the appointment desk and not private or clinical information.

**Cell phone to which information may be texted: _____**

*****I fully understand and (circle one) [accept / decline] the terms of this consent*****

_____ _____

**Patient's Name** **Date**

_____

**Patient/Parent's Signature**