Dimensional Dental™

Name of the Patient: ____ Date of Birth (mm/dd/yyyy): _______________

SECTION A: NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

Purpose: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Consent: I, the undersigned, have had full opportunity to read the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature of Patient/Parent/Legal Guardian: ____________________________________ Date: ___________________________________

Name of Parent/Legal Guardian: ____ Relationship to Patient: _____________________

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice of your revocation to the Privacy Officer listed in our Notice.

SECTION B: CONSENT FOR FAMILY MEMBER

Consent: I, the undersigned, understand that by signing this Consent form, I am giving my consent to disclose and discuss my protected health information with the following family member or friend, in order to carry out treatment, payment activities and health care operations

Name of Family Member or Friend: ____ Relationship: _________________________

Signature of Patient/Parent/Legal Guardian: ____________________________________ Date: __________________

Right to Revoke: You will have the right to revoke this Consent at any time by giving written notice of your revocation to the Privacy Officer listed in our Notice

SECTION C: CONSENT TO SHARE PATIENT RECORDS

Purpose: We are a member of a group of offices supported by Dimensional Dental Management, LLC. In the event that we need to refer you to another office supported by Dimensional Dental Management, LLC and you agree to the referral, we will transfer your patient records to facilitate your referral. Any such transfer of records will be performed free of charge. This is done as a convenience for you, and to ensure that you receive the best care possible. For more information on our supported offices, please ask the front desk or visit www.dimensionaldental.com

Consent: I, the undersigned, understand that, by signing this Consent form, I give consent to share my patient records with another office supported by Dimensional Dental Management, LLC, in the event that a referral is required and mutually agreed upon.

Signature of Patient/Parent/Legal Guardian: ____________________________________ Date: ___________________________________

SECTION D: CONSENT TO RECEIVE PATIENT NOTIFICATIONS

Purpose: In order to ensure that patients receive time-sensitive information and other informational healthcare messages, we send email and/or text notifications to patients. Signing this consent will indicate to us that you wish to opt-in to receive such notifications. You may opt-out of receiving these communications at any time. We will not impose a separate charge for these notifications but message/data rates may apply. It is important to note that certain communications, including, without limitation email and text message, which may contain your protected health information, are not invariably secure since certain communications can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission.

Consent: I, the undersigned, hereby consent to receive notifications, which may include my protected health information, by the following methods of communication that I have indicated below, with a full understanding of the risks involved with such notifications.

☐ Text: (_____)____ ☐ Please check here if you do not wish to receive voicemails at this number

☐ E-Mail: ____

☐ Opt-out of receiving text message ☐ Opt-out of receiving email communications

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 ☐ Communication barriers prohibited obtaining the acknowledgement ☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify) ____

Signature of Office Staff: ____ Date: ___________________________

You are entitled to a copy of the signed consent