Acknowledgement of receipt of Notice of Privacy Practices

We are required by applicable federal and state law to maintain the privacy of your health information. We adhere to strict privacy practices concerning your health information as this is our legal duty. We will only disclose your health information to a physician or other healthcare provider providing treatment to you or if additional information was requested by your insurance carrier to clarify services to obtain payment for services rendered. We can provide you with a complete copy of the Notice of Privacy Practices if you so desire.

Please complete and sign the section below

I approve to contact me through:

- ☐ Voicemail
- ☐ Email *(Responding "C" for Confirm will officially confirm my appointment and end further confirmation email's)*
- ☐ Text *(Responding "C" for Confirm will officially confirm my appointment and end further confirmation texts)*

- ☐ I **DO NOT** approve to contact me through voicemail, text, and email

I, ________________________________ (print name) have reviewed the offices Notice of Privacy Practices.

Sign: _______________________________________ Date: ___________________

If signing for a minor, please list names below for any family member's approved to release information to while he/she is a patient at our practice. (ie: step-parents, grandparents, family friends, etc.)

____ ____

____ ____

Thank you for your cooperation in this manner.

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For office use only below this line:

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

- ☐ Individual refused to sign
- ☐ Emergency situation prevented obtaining acknowledgement
- ☐ Communication barrier
- ☐ Other (please explain) ________________________________

Dentistry of Wisconsin
1507 N. Center Street, Beaver Dam, WI 53916 920.887.2112
412 Shaler Drive, Waupun, WI 53963 920.324.3881