



531 E. Roosevelt Road • Suite 100 • Wheaton, IL 60108 • 630-529-0303

Acknowledgment of Receipt of Privacy Practices Notice & Communication Preferences

Section A: The Patient

Name: _____

Address: _____

Telephone: _____ E-Mail: _____

Section B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from Arden Dental.

I give Arden Dental permission to speak to the following regarding:

	Appointments	Treatment	Bills
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Section C: Cell phone Consent

I, _____, consent to the dental practice using my cell phone regarding appointments, treatments, and my account. I understand that I can withdraw my consent at any time.

- call
- text

Signature _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representatives Name: _____

Relationship to individual: _____

Signature: I attest that the above information is correct

Signature: _____ Date: _____

Print name: _____ Title: _____

<p>FOR OFFICE PERSONNEL ONLY</p> <p><u>Section C: Good Faith Effort to Obtain Acknowledgement of Receipt.</u></p> <p>Describe your good faith effort to obtain the individual's signature on this form:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Describe the reason why the individual would not sign this form: _____</p> <p>_____</p> <p>_____</p>
