Chad H. Galbraith, D.D.S. and Jennifer C. Veltkamp D.D.S.

Acknowledgement of Receipt of Notice of Privacy Practices

Date: _____

The undersigned that our patients have access to the currently effective Notice of Privacy Practices for this healthcare facility (posted in reception). If you would like the policies for your records, please ask. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a Protected Health Information Document Release should I request treatment information or radiographs/photographs be sent to other attending dentist/doctor/facilities in the future.

_____ _____

Patients' name (please print) *Parent or Guardian's name (Please print if different)*

_____

Signature (Patient or Parent/Guardian

OPTIONAL DISCLOSURES

By checking the boxes below, you indicate your consent to our disclosure of your health and financial records to the persons listed below. This may, for example, include such things as discussing your dental condition and treatment needs, payment arrangements and appointment scheduling.

Please list any other parties who can have access to your dental information (this includes scheduling appointments and payment arrangements and making payments).

Child/Teen Patients

[ ] My parent(s) (please list names)_____

[ ] Persons accompanying my children if I am not present during their dental appointments.

All Patients

[ ] Persons I have listed below (additional family members, friends, or others who are involved in my care or payment of my care):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please Initial

● *Future appointment confirmation will be completed via text only with your mobile # provided on the New Patient form.* _____

● *I authorize the mailing/emailing of payment receipts if and when I request them.* _____