PRIVACY PRACTICES ACKNOWLEDGEMENT AND RECEIPT

I, _____, have read and understand ALASKA SMILES Notice of Privacy Practices, (HIPAA). I give my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

PATIENT SIGNATURE: _____ DATE: _____

PERMISSION TO RELEASE PRIVATE HEALTH INFORMATION

☐ **PLEASE DON'T SHARE MY DENTAL INFORMATION**

I give permission for the following people to have access to my private health and account information:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

I give permission to employees and staff of ALASKA SMILES to share my dental care and/or health history including records, diagnosis, recommended treatment, dates of any treatment recommended or rendered and costs of services and payment received associated with them. I acknowledge that this permission is optional and can be revoked by me in writing at any point in time. I also understand that this permission is in addition to permissions granted by signing ALASKA SMILES Privacy Practices and shall remain in effect until revoked.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT CONSENT FOR ELECTRONIC COMMUNICATION

☐ **DECLINE SERVICE**

Our office would like to communicate with you electronically via email and text. By utilizing our practice's electronic services, you agree that *ALASKA SMILES* may communicate with you regarding information about your invoice, accounts payable, insurance, dental treatment any dental visits. We do NOT give your email address to marketing companies.

I agree that the practice may electronically communicate with me at the following email address:_____.

PATIENT SIGNATURE: _____ DATE: _____

OFFICE AND FINANCIAL POLICIES

I have read and understand the Office and Financial Policies. I have had the opportunity to ask any questions and I agree to comply with the policies. I certify to the best of my knowledge that all information I have been provided is accurate and true. By signing this agreement, you agree to pay for any costs we estimate due to us at the time of services being provided.

PATIENT SIGNATURE: _____ DATE: _____