PRIVACY POLICY (HIPPA)

Child's Name: _____ Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I have received a copy of this office's Notice of Privacy Practices on this date. I understand that by signing this form I consent to our use of my protected health information to carry out treatment, payment, activities, and healthcare operations. Your office will continue to use my information in some of these ways; by calling me first and last name from your waiting room, by mailing me reminders of my appointment and by calling to confirm appointments, as described in our Notice of Privacy Practices.

Signed (parent/guardian): _____ Date: _____

ANSWERING MACHINE MESSAGES

_____ (initials) I consent to the office leaving a message on my answering machine to confirm future appointments.

_____ (initials) I do not wish to have the office leave a message on my answering machine to confirm future appointments.

PREMEDICATION REMINDER

_____ (initials) I consent to a reminder on either a recall card or a phone message stating "remember to take your premedication."

SIGNATURE ON FILE

I hereby authorize Great Beginnings Pediatric Dentistry to affix my name to any and all claims and documents as related to any and all health benefits to me and my dependents. I hereby authorize payment of dental benefits to the office of Great Beginnings Pediatric Dentistry. A photo of this document shall be considered valid.

Parent/Guardian Name (please print): _____

Signature: _____ **Date** _____