



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

You may refuse to sign this acknowledgement but, in refusing we will not be allowed or able to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Osprey Dental LLC. A copy of this signed, dated Acknowledgement shall be as effective as the original.

\_\_\_\_\_  
Please **print** your name

\_\_\_\_\_  
Please **sign** your name

\_\_\_\_\_  
Legal Representative

\_\_\_\_\_  
Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:  
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation
- Home Phone Confirmation
- Work Phone Confirmation
- Text Message to my Cell Phone
- Email Confirmation

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- Message on Cell Phone
- Message on Home Phone
- Message on Work Phone
- Text Message
- Email Message
- In-Person
- Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW DENTAL INFO** via:

- Phone Message
- Text Message
- Email
- Any of the above**

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**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment \_\_\_\_\_
- I could not communicate with the patient \_\_\_\_\_
- The patient refused to sign \_\_\_\_\_
- The patient was unable to sign because \_\_\_\_\_
- Other (please describe) \_\_\_\_\_

\_\_\_\_\_  
Signature of Privacy Officer