Dental Arts S.C.

404 Wisconsin Avenue, Amery, WI 54001

Notice of Privacy Practices Acknowledgement Form

Patient's Name: (First Name, Last Name):	Date of Birth:

I understand that as part of my dental care, Dental Arts S.C. creates and maintains health records that describe my health history, dental information, symptoms, examinations, test results, diagnosis, procedures, treatment, and plans for future care or treatment I may receive. I understand that health information collected and stored will be used for the following:

- To support my care and treatment at Dental Arts S.C. (treatment)
- For continued treatment among health professionals who are involved and contribute to my health care (treatment)
- For billing purposes including information regarding my diagnosis, treatment, and services rendered (payment)
- For insurance claim processing by a third-party payers for verification of services billed (payment)
- A tool for routine healthcare operations such as assessing quality improvement (healthcare operations)

I understand that the Notice of Privacy Practices from Dental Arts S.C. defines more information regarding the use and disclose of my protected health information as well as my rights to my health information. By signing this, I acknowledge that Dental Arts S.C. has offered me a copy of their Notice of Privacy Practices. I acknowledge and understand the rights that I have over my protected health information. I authorize the use and disclosure of my protected health information as specified in the Notice of Privacy Practices. I authorize the use and disclosures for treatment, payment, and healthcare operations purposes for Dental Arts S.C..
I authorized Dental Arts S.C. to communicate regarding my dental treatments to the following individual(s):

_____

_____

I understand that I am ultimately responsible for all charges incurred for dentistry performed at Dental Arts S.C. office including balances left after insurance payment has been received.

I understand that Dental Arts S.C. communicates through text messaging about appointment reminders that contain patient specific information. I agree to the communication through text messaging unless I select the box below.

I do not wish to receive text message communication for appointment reminders (Check to Opt Out)

This consent will continue forever unless I cancel it by writing to: Dental Arts S.C., 404 Wisconsin Avenue, Amery, WI 54001; if the consent is cancelled, it will not change releases that have already been made prior to the date of cancellation.
I don't want the consent to never expire, please expire the consent as of: _____.
I understand that I can get an electronic copy of the Notice of Privacy Practices at www.amerydental.com.

_____ _____

Patient's Signature/Legal Representative Signature Date (MM/DD/YYYY)

If Legal Representative, relationship to Patient (parent, guardian, ect) _____

Optional: Please e-mail me a copy of the Notice of Privacy Practices to the following e-mail address:

Internal Use:

If patient refuses to sign, please have 2 staff members of Dental Arts S.C. Sign Below:

_____ _____

Staff's Signature Staff's Signature

Reason for Refusal of Signature: _____