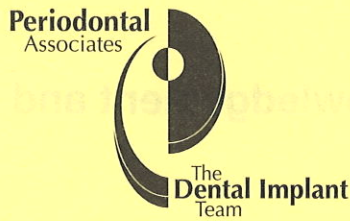


Kenneth J. Versman, DDS, MS  
Douglas A. Heller, DMD



Paul L. Glick, DDS, MS  
Eric M. Beckman, DDS, MS

Colorado's Premier Provider of Dental Implants & Periodontics

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

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_ have reviewed a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

**OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_

**USE AND TRANSFER OF PERSONAL INFORMATION**

I authorize the staff of Periodontal Associates to take photographs, slides, models, and/or videos of my face, jaws, mouth and teeth and to record dental clinical findings and dental history/habits. I understand and agree that these photographs, slides, models, videos, dental clinical findings, and/or dental history/habits may be used for educational purposes in lectures, seminars, demonstrations, study groups and professional publications and that my identifying information will be kept confidential.

\_\_\_\_\_  
{Patient's/Parent's Signature}

\_\_\_\_\_  
{Date}

I understand that if any personal information is sent by Periodontal Associates via e-mail that it may be unencrypted.

\_\_\_\_\_  
{Patient's/Parent's Signature}

\_\_\_\_\_  
{Date}

**Periodontal Associates • The Dental Implant Team**

2900 South Peoria Street, Building D • Aurora, Colorado 80014  
(303) 755-4500 • Fax (303) 755-4047 • www.periodontalhealth.com

# Patient Acknowledgement and Consent Form

I give consent for my treatment to be discussed with the following individuals: (e.g., spouse, parent, adult child, caregiver)

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(please print names)

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I also give my permission for information regarding \_\_\_\_\_ appointments, \_\_\_\_\_ insurance benefits, \_\_\_\_\_ financial arrangements to be discussed with the above individuals, except: \_\_\_\_\_

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Patient's/Parent's Signature

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Date