Periodontal Associates
The Dental Implant Team

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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}

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)

_____

(please print names)

_____

_____

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

_____

_____
Patient's/Parent's Signature

_____
Date