Hendrix Family Dentistry

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of this office's Notice of Privacy Practices. I grant Dr. R. Boyd Hendrix and his staff permission to use and/or discuss my personal information to or with the following:

_____ Insurance Company

_____ Other Health Care Providers (referrals)

_____ Other person/ persons: Name: _____ relationship: _____

Name: _____ relationship: _____

Name: _____ relationship: _____

Name: _____ relationship: _____

NOTIFICATION OF APPOINTMENTS:

May we leave a message on your cell phone? Yes _____ No _____
May we leave a message on a machine at your home? Yes _____ No _____
May we leave a message with someone other than you at your home? Yes _____ No _____
May we leave a message on a machine at your work place? Yes _____ No _____
May we leave a message with someone other than you at your work place? Yes _____ No _____
May we send you a reminder card via mail? Yes _____ No _____

_____
Please Print Your Name

_____ _____
Signature Date

For Office Use Only

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

- _____ individual refused to sign.
- _____ communication barriers prohibited obtaining the acknowledgement.
- _____ an emergency situation prevented us from obtaining acknowledgement
- _____ Other (please specify) _____