

PATIENT CONSENT/ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Barry J. Glaser, DMD, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices (“Notice”). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office and requesting a revised Notice. We will also post any revised notice in the reception area.

You have the right to request that we restrict our uses of disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use of disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

This form is also used to obtain acknowledgment of receipt our notice of privacy practices or to document our good faith effort to obtain that acknowledgment.

I have reviewed, understand and agree to the consent of the Notice of Privacy.

PATIENT’S NAME _____ DATE _____

Please print

Signature _____

If you chose not to sign this CONSENT/ACKNOWLEDGMENT of Notice of Privacy
Please specify the exact reason below.

SEE OTHER SIDE

SUPPLEMENTAL CONSENT/ACKNOWLEDGMENT FORM

By signing below and checking “yes”, you consent to allow Barry J. Glaser DMD, PC, to do the following.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1) Display your first name and photograph in our office. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Display your first name and photograph on our website. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Use your orthodontic records for educational purposes. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Have your signature on file for insurance purposes. | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT'S NAME _____ DATE _____

SIGNATURE _____