Eric D. Hannapel, D.D.S., M.S., P.C.

Patient Acknowledgement of Receipt of Notice of Privacy Policies

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Date: _________________

Patient Name: ____

Responsible Party Name: ____________________________ Responsible Party Signature: _____________________________

Preferred Means of Communication

Please sign this form below under the heading "Preferred Means of Communication" to acknowledge that the contact information on the Health History form is your preferred method of communication.

I acknowledge that the contact information on the Health History Form is my preferred method of communication.

Preferred Telephone Number: ____________________________________

Preferred Email Address: ____________________________________

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement:

____

An emergency situation prevented the patient from signing the acknowledgement.

______________________________ ______________________________

Office Personnel (signature) Office Personnel (print name)

Date:

Responsible Party Name: ____________________________ Responsible Party Signature: _____________________________

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosure of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosure of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Responsible Party Name: ____________________________ Responsible Party Signature: _____________________________