Preferred Method of Communication

My preferred method of communication regarding my <u>treatment, financial, and/or appointment information</u> is indicated below:

○ **Phone**   ○ **Mailed letter**   ○ **Guardian**

If the above method of communication is by phone, please do one of the following (Please check ONE):

○ Leave a message with **detailed information**

○ Leave a message with a **call back number only**

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like us to call you at a different phone number for specific information or if you do not want to be contacted at all.

Approved HIPAA Contacts

If you would like to add additional contacts other than the patient or legal guardian that Schroeder Family Dentistry is allowed to disclose this type of information to, please complete all fields below.

Name	Relationship to Patient	Contact Information

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

(You may refuse to sign this acknowledgement)

Date: _____