Northern Illinois Endodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have viewed a copy of this office's Notice of Privacy Practices.
Please Print Name

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this contract. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we may maintain. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures based on your prior consent.

Our office will communicate with you regarding your appointments. We will mail you a six month recall card. If necessary, we may contact you regarding your account balance. Should you not be able to take our phone call, we will leave a message regarding the necessary information. Your signature will allow us to leave the above messages on an answering machine, voice mail, e-mail or with another person.

____ ____________________
Signature of Patient or Guardian Date
Signature Of Patient Or Parent If A Minor

FAX PRIVACY WAIVER

I understand that my dental records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve Northern Illinois Endodontics of all liability. I give my consent to fax my records for the purposes of treatment, payment or healthcare operations and understand that I may withdraw this consent at anytime in writing.

____ ____________________
Signature of Patient or Guardian Date

Signature Of Patient Or Parent If A Minor