Dr. John Schmid, D.D.S.
Contemporary Cosmetic Dentistry

Notice of Privacy Practices Receipt

I acknowledge that I have received the Notice of Privacy Practices of Dr John Schmid that explains when, where and why my confidential health information may be used or shared. I acknowledge that the doctors, hygienist, assistants and other staff of Dr John Schmid may use and share my confidential health information with others in order to treat me, to arrange for payment of my bill and for issues that concern the Practice's operation and responsibilities.

Print Name of Patient:_____

Patient's Date of Birth:_____

Please Initial Appropriate Statements Below:

_____ Ok to fax or email my medical information to me or other medical providers

_____ Ok to send appointment reminders via email_____, text message_____or call to remind me at home_____work_____cell_____

_____ Ok to leave detailed messages (anything to do with your care): work voicemail_____home voicemail_____ family member_____

_____Leave only limited information (i.e. call back name and number): work voicemail____home voicemail_____ family member_____

_____ Ok to communicate with me by email____ Home_____
____Work_____

_____ Ok to email my photos to the dental laboratory

Other: _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative Relationship to Patient

For Office Use Only:

_____ Patient refused to sign acknowledgement form.

Comments:_____
_____

_____ _____
Signature of Office Employee Date