Patient Privacy Directive

In our effort to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave messages at home cell phone to discuss appointments? **Yes No N/A**

May we text you messages to confirm or discuss your appointments? **Yes No N/A**

May we email you to confirm or discuss appointments or treatment? **Yes No N/A**

May we leave messages with or discuss your appointments/treatment with your spouse?

Spouses Name:_____ **Yes No N/A**

May we leave messages concerning your appointments with a receptionist or secretary that regularly answers your calls?_____ **Yes No N/A**

If you are over the age of 18, still living at home, may we discuss your appointments/treatment with your parent(s) or guardian? Name:_____ **Yes No N/A**

If you are over the age of 18, may we discuss your appointments/treatment with your children?

Name:_____ **Yes No N/A**

What is the best way to communicate with you? Please list in order the best form of communication.

(Example cell/text/home/email/work)

1._____ 2._____ 3._____ 4._____

Any other additional contact may be listed here._____

Social Media I like use **Google** **Yelp** **Yahoo** **Facebook**

You must inform us, in writing, of any changes in your directives. This record takes effect upon signing and dating this form. It will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

I acknowledge I have received a copy of the "Notice of Privacy Practices"

Signature:_____ Date:_____

Printed Name:_____ Date of Birth:_____

Relationship to Patient:_____

Patient Name:_____ Date of Birth:_____

You may use this form for other patients in the family under the age of 18

Patient Name:_____ Date of Birth:_____

Patient Name:_____ Date of Birth:_____

South Arlington DENTAL CARE
Creating Smiles with a Gentle Touch