Dr. David R. Bowser III

Cosmetic & Family Dentistry

Patient Consent to receive mail and/or telephone messages

____

Please Print (Last Name) (First) (M.I.)

Do we have your permission to: Y N

Send a recall appointment reminder to your home? ☐ ☐

Leave appointment, billing or dental information on your answering machine/voicemail/e-mail? ☐ ☐

I ______________________________ give permission to share appointment, billing, or dental information with the person/persons who I have named below:

____

____

Name: ____ Date: ________

Signature of Patient/Parent/Legal Guardian

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14, 2003 (HIPAA).

____ Date: ________

Signature of Patient/Parent/Legal Guardian

CONFIDENTIAL