

**Reflections Orthodontics, P.C.**

*Privacy Is Important to Us*

**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge receipt of the Notice of Privacy Practices of Reflections Orthodontics, P.C.. I also hereby authorize, as indicated by my signature below Reflections Orthodontics, P.C. the following means of communication to include third-party vendors for appointment reminders and surveys.

\_\_\_\_\_  
Patient Name Address

\_\_\_\_\_  
Patient Signature (parent/guardian/authorized representative) Date

**Please check our preferred means of communications:**

- \_\_\_\_\_ You may contact me at my home number to include a message. \_\_\_\_\_
- \_\_\_\_\_ You may contact me on my mobile number to include a message. \_\_\_\_\_
- \_\_\_\_\_ You may contact me on my work number to include a message. \_\_\_\_\_
- \_\_\_\_\_ You may send me an email at: \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

I authorize sharing my protected health information (if minor the above named patient) with the following individuals who may be involved in my care and I understand I am responsible to notify the Practice of any changes.

- 1. \_\_\_\_\_ Relationship: \_\_\_\_\_ Date \_\_\_\_\_
- 2. \_\_\_\_\_ Relationship: \_\_\_\_\_ Date \_\_\_\_\_
- 3. \_\_\_\_\_ Relationship: \_\_\_\_\_ Date \_\_\_\_\_
- 4. \_\_\_\_\_ Relationship: \_\_\_\_\_ Date \_\_\_\_\_

If you wish to NOT participate in third-party vendors for appointment reminders and surveys. Please opt out here: \_\_\_\_\_ . (Please sign)

**For Office Use Only:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy practices, but acknowledgement could not be obtained because: (check one)

- \_\_\_ Individual refused to sign
- \_\_\_ Communications barriers prohibited obtaining the acknowledgment
- \_\_\_ An emergency situation prevented us from obtaining the acknowledgement
- \_\_\_ Other (Please Specify) \_\_\_\_\_

**Staff Person Initials** \_\_\_\_\_