

Privacy Policy



PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

I, _____, have received and/or reviewed a copy of the
(Patient's Name)

Notice of the Privacy Practices for the office of
Sherman Oaks Dental & Dental Sleep and TMD Center of Illinois.

Please sign and date: _____ Date: _____
(parent signature if a minor)

Please Check box **only** if **OPTING OUT**:

- I **do not** want appointment reminder messages left on my home answering system;
I understand that the office may charge me should I fail to keep my appointment.
- I **do not** want appointment reminder messages left at my place of employment;
I understand that the office may charge me should I fail to keep my appointment.
- I **do not** want appointment reminders by e-mail.
- I **do not** wish my protected health care information to be released to the following
persons _____ .
(give name and address)
- I **decline** to sign the Acknowledgement.

OFFICE USE:

The office was unable to obtain a signed Acknowledgement form from the above patient for the following reasons: