SAMUEL F. JIRIK, DDS
IMPLANT, COSMETIC & GENERAL DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)
Dr. Samuel F. Jirik, DDS P.A.

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

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:

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

Communication Preferences

As a courtesy to our patients, our office utilizes a personal phone reminder 1-2 days prior to regularly scheduled appointments. Patients may also elect to enroll in postcard reminders or email confirmations. By signing below, you grant permission for our office to contact you and/or leave a message on your home, place of employment or cell phone number provided.

_____

Patient/Guardian Signature **Phone number for messages/Email**

*If you would like to enroll please provide and circle. **Postcard/ Email/ Both.**_____

By enrolling patients are required to notify the practice of any changes/updates to communication preferences. Our practice has taken precautionary measures to secure all communications, however there is always some level of risk in third party communications.

To the Patient, Use the following lines: To grant our dental practice permission to communicate with someone other than you, in regards to your care**.**

Name/Relationship _____ **Contact #** _____

Name/Relationship _____ **Contact #** _____

Name/Relationship _____ **Contact #** _____

Name/Relationship _____ **Contact #** _____