



by
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specialsmilesdentistry.com

Acknowledgement of Receipt of Privacy Practices Notice (HIPPA):

- I acknowledge that I have received a Notice of Privacy Practices from the above-named practice.
- I acknowledge that I have been given the opportunity to ask questions regarding privacy practice.
- I understand I may update and/or change this information at any time.

Patient Name/Signature

Date

I give permission for Special Smiles Pediatric dentistry to discuss my dental care/needs and financial obligations with the following:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

I understand I may update and/or change this information at any time.

Patient Name/Signature

Date

I give permission for you to contact me regarding appointments, treatment or insurance or financial purposes by:

- _____ Leave a message with person answering the telephone
- _____ Phone/Voice Mail/Messaging
- _____ Text Messaging
- _____ Email Address: _____
- _____ Postcard
- _____ Other: _____

Patient Name/Signature

Date