Sethi Smiles Orthodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, the undersigned, have been issued (if requested) a copy of this Practice's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this form and the Notice. I fully understand that Sethi Smiles Orthodontics (Sethi Orthodontics PLLC) is required by law to maintain the privacy of my medical and health information. By signing this form, I acknowledge that the Practice will use and disclose any health information for purposes of my treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), for payment activities (e.g. obtaining payment from third party payers such as my insurance company) and for conducting health care operations of the Practice. I assume responsibility to inform the practice of any changes to this form or to my information.

_____ _____

Please Print Patient's Name **Patient Date of Birth**

_____ | _____ | _____

Signature of Patient / Responsible Party **Print Name** **Date**

I am (circle one):

Patient Spouse Parent Guardian Responsible Party (specify relation to Patient: _____)

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---------- 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):

_____

_____

_____

Authorization to Release Information

I, _____ (Print Your Name) the undersigned, am the patient or have the legal authority to sign on behalf of the patient and hereby authorize the Practice (Sethi Orthodontics PLLC), and its doctor(s) and staff, to share any and all medical, dental, and financial information with the following individual(s) on behalf of myself or the patient, _____ (Print Patient Name).

Name	Phone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ At this time, I do not authorize anyone else other than parent(s)/guardian(s).

I understand that this authorization to anyone other than myself or the child's other parent/guardian is voluntary and I can revoke this authorization at any time.

Consent for Communications

By providing my mobile number and/or email address, I consent to receive automated and non-automated communications from the Practice (Sethi Orthodontics PLLC), including appointment reminders, inclement weather notifications, treatment updates, and other important information. Message and data rates may apply for texts. I understand that my consent is not a condition of receiving treatment or services. I may opt out of these communications at any time by clicking the link or by contacting the practice directly. I understand that these communications are intended to enhance my convenience and streamline communication with the Practice.

Signature of Patient / Responsible Party	Print Name	Date