

EBNER FAMILY DENTISTRY

6605 West 38th Ave.

Wheat Ridge, CO. 80033

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have read and have had the opportunity to request a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

Authorization to Leave Detailed Messages

Occasionally it is necessary for the staff of Ebner Family Dentistry to leave messages for patients. The purpose of these messages are to notify the patient of upcoming appointment times, discuss treatment needs, billing purposes or to ask a patient to call back regarding an issue or concern. To expedite the receipt of the needed information, please indicate below if you would like to give consent to leave detailed messages. Please mark your preference below:

_____ I authorize Ebner Family Dentistry to leave detailed voicemails.

This is the phone # I would like messages left: _____

_____ I authorize Ebner Family Dentistry to send detailed emails.

This is the email address I would like messages sent: _____

_____ I do not want any detailed messages left on voicemail or sent via email.