ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement **

I, ______________________________________, have received a copy of this office's Notice of Privacy Practices.
(Please Print Name)

I give permission to Dr. Bruce Nelson and staff to speak with ______________________________________.

______________________________ ______________________________

(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)

____

____

Consent to Use

Of Photograph, Likeness, Picture, Name, Comments, Testimonial, or Voice by Bruce L. Nelson, DDS, PC
I, ______________________________ (name), do hereby fully and freely consent to use, by Bruce L. Nelson, DDS, PC and/or its agents and assigns, of my photograph, picture, name, comments, testimonial, and/or promotion or advocacy of Dr. Bruce Nelson and Bruce L. Nelson, DDS, PC.

I do here release and hold harmless Bruce L. No here release and hold harmless Bruce L. Nelson, DDS .PC and/or its agents and assigns from any liability with regard to the above stated purposes arising out of said consent or use. I hereby grant to Bruce L. Nelson, DDS. PC and/or its agents and assigns the right to use my photograph or likeness, picture, name,comments. testimonial . and/or voice to advertise and publicize the interests of Bruce L. Nelson, DDS, PC.

______________________________ ______________________________

(Signature of Patient) (Date)

______________________________ ______________________________

(Signature of Parent or Guardian) (Date)
(If patient is under 18 uears of age)

______________________________ ______________________________

(Signature of Witness) (Date)

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prior written approval of the American Dental Association.
This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

You have requested that our practices communicate with you electronically. By utilizing our practice's electronic services, you agree that Bruce L. Nelson D.D.S., P.C. may send to you any of the following that you identify as communication that can be sent through the Internet to an email address you designate.

Consent and Acknowledgement

I ________________________, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the follow ing email address or cell phone number.

____ ______________________________________

(Cell phone number) (Email Address)

Patient's Date of Birth (for verification purposes)________________________

I acknowledge that the practice may send the following to my email or cell phone. Check each that apply, and then provide your initials at the end of each item selected.

Information about my invoice or accounts payable. Information about a specific dental visit. Information about any dental visit.

- ■ Information about my invoice or accounts payable. __________(initials)
- ■ Information about a specific dental visit. __________(initials)
- ■ Information about any dental visit. __________(initials) Specify: _________

Acknowledgement

You must acknowledgement each of the following before we can send communicat ions electronically.

- ■ All electronic communications from our practice will be encrypted.
- ■ I am responsible for providing the dental practice any updates to my email address or cell phone number.
- ■ I am able to receive information electronically and store it securely away from any public computer.
- ■ I can call withdraw my consent to electronic communications by calling (602}678-4500.

____ ______________________________________

Patient's Signature Date