Last Name	First Name	Date of Birth

Privacy Policy

Notice of Information & Privacy Practices | HIPAA Communication Form

I have been given a copy of Professional Dental Alliance practice ("Practice"), *Notice of Information and Privacy Practices* **("Notice"), which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at compliance@nadentalgroup.com or by visiting the Practice's web site.**

Patient privacy is important to us. Our policy to keep patient health information confidential and not disclose such information without your consent or written authorization unless otherwise required by federal or state privacy laws.

Please provide names of individuals with whom we can communicate concerning you or your child's health information and care. This may include family members, friends, organizations, caregivers, and babysitters.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please note: If you have someone accompany you in the treatment area, we will assume this person is entitled to receive information regarding your care and we can freely discuss your health information.

Patient Communication - Our practice is to protect the privacy of our patients while ensuring our patients are kept well informed of their appointments and other information. As a service to our patients, we will communicate appointment reminders and other healthcare related and bill information via text message, email or phone. These messages may come from an automated notification system. In addition to the above healthcare messages, we will communicate with you through text message from an automated patient notification system regarding your dental bill, surveys regarding your dental care, services or products related to your dental care or other communications related to your dental care and our practice. Limited information will be left when leaving a voice message. Medical information will not be shared when leaving a voice message. Please inform our team if you would prefer that we use an additional communication preference for appointment reminders or other information related to your care. You are free to make changes to your preferences at any time by completing a new form.

My signature below acknowledges that I have been offered and/or provided with a copy of the Notice of Information and Privacy Practices. By providing us with your mobile number, you consent to receive these messages, including appointment reminders and other health-care related information by text message, voicemail, and email to the phone number(s) and email address that I have chosen to provide below:

Mobile Phone Number	Home Phone Number	Email Address

Print Name and/or Representative's Title (*e.g., Guardian, Executor of Estate, Health Care Power of Attorney)*

Patient or Guardian Signature	Date