

Jones Cosmetic & Family Dentistry
1509 Robinson Road
Old Hickory, TN 37138-2811
PH: (615) 847-3530 FAX: (615) 847-4665

Acknowledgement of Receipt of Privacy Practices Notice (HIPAA):

- 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 Jones Cosmetic & Family 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
(You may add more names/relationships on the back of this form, if needed. Please sign and date the back, also. Thank you.)

RELEASE OF RECORDS:

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing.

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 phone
- Phone/Voice Mail/Messaging
- Text Messaging
- Email Address: _____
- Postcard
- Other: _____

Patient Name/Signature Date