C & B Orthodontics

Crystal R. Cox, D.D.S., M.S.
Jeff N. Berndt, D.D.S., M.S.

ACKNOWLEDGMENT OF AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, the undersigned, have been informed that a copy of this office's Notice of Privacy Practices is available upon request.

_____

Print Name

_____

Signature

_____

Date

_____

Capacity of Person Signing: Self/Parent/Legal Guardian

For Office Use Only

We attempted to obtain written Acknowledgement of Availability of Our Notice of Privacy Practices but the Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining the Acknowledgment (Please Describe):

  _____

  _____

- ☐ Other (Please Specify):

  _____

  _____

  _____

Name of Employee Completing Above: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of protected health information to carry out treatment, payment activities, and healthcare operations.

Patient Information:

Name: _____

Address: _____
Street

_____
City/State/Zip Code

Telephone: (___)_____

Signature:

_____
Print Name

_____
Signature

_____
Date

_____
Capacity of Person Signing: Self/Parent/Legal Guardian