



# COLUMBUS GROVE FAMILY DENTISTRY

QUALITY CARE FOR ALL AGES

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## Acknowledgement of Receipt of Notice of Privacy Practices, Communications Rights and Appointment Policy

Patient's Name: \_\_\_\_\_

I have received a copy of Columbus Grove Family Dentistry's Notice of Privacy Policy.

**Please note:**

- It is the policy of this office to confirm patient appointments and leave voice messages and/or text messages at phone numbers provided by our patients/guardians.
- It is the policy of this office to leave phone messages and/or text messages requesting our patients to call us concerning health care issues.

**To that extent:**

- I authorize my healthcare/dental provider and/or any entity authorized by my healthcare/dental provider, including those using automated dialing systems, automated messages, email, text messaging, or other electronic communication to contact me for any reason by using any telephone number, cellular or otherwise, email address, and/or mailing address provided.

**I UNDERSTAND THAT BY FILLING IN THE INFORMATION BELOW I AUTHORIZE YOUR OFFICE TO CONTACT ME BY ANY AND ALL MEANS I HAVE LISTED.**

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Check here if you **DO NOT** want to receive text messages: \_\_\_\_\_

Email Address: \_\_\_\_\_

List of individuals who we may share dental health, payment, and appointment information with:

NAME:	RELATIONSHIP:
_____	_____
_____	_____

**Authorization:**  
 Patient's Name (Printed): \_\_\_\_\_  
 If Under 18, Parent/Guardian's Name (Printed) \_\_\_\_\_  
 Signature of Patient OR Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Appointment Policy:** If you need to cancel and/or change your appointment, please give us a minimum of 48 hours' notice. We reserve the right to charge a \$50.00 broken appointment fee if this courtesy is not granted.