



HOW WOULD YOU LIKE TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

\_\_\_ First Name      \_\_\_ Last Name      \_\_\_ Other \_\_\_\_\_

I AUTHORIZE contact from this office to CONFIRM my appointments OR Treatment and billing information via:

\_\_\_ Cell Phone    \_\_\_ Home Phone    \_\_\_ Email    \_\_\_ Text Message

**If you would like to give Lemay Family Dentistry, LLC permission to discuss your Private Health Information with someone other than yourself, please print their names below.  
(ex: spouse, parents, children, friends, etc.)**

\_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_ Relationship: \_\_\_\_\_

**PLEASE PRINT AND SIGN BELOW**

\* You May Refuse to Sign This Acknowledgment\*

**I have received a copy of this office's Notice of Privacy Practices.**

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient, Parent, or Guardian Signature

**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)

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