

Tom Kelly, D.D.S and Shannon Kelly, D.M.D

## Acknowledgement of Receipt of Notice of Privacy Practices; Consents to Communications

TO BE COMPLETED BY THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE  
(E.G., Patient's PARENT OR LEGAL GUARDIAN)

Patients Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

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

Personal Representative completing the form: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (this includes step parents, grandparents, and any caretakers who can have access to this patient's records):**

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

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

I acknowledge receipt of this dental office (Dr. Tom Kelly DDS and Dr. Shannon Kelly DMD) Notice of Privacy Practices. I understand I can request a copy of the Notice of Privacy Practices, at any time.

I consent to receive recall appointment reminder information at the mailing address on file with the Practice.

I consent and agree to receive calls and text messages from or on behalf of the Practice and its affiliates at the home and/or mobile phone numbers on file with the Practice. These calls and text messages may include (but are not limited to) those concerning my health care, my account and insurance, and the Practice's services and may include marketing content. These calls and texts may be placed using automatic dialing or pre-recorded/ artificial voice technology, and standard message or data rates may apply. I understand that my consent is voluntary and is not a required condition for receiving care from the Practice.

I understand that I can unsubscribe at any time by calling the Practice or replying "STOP" to a text message from the Practice or its applicable affiliate.

I consent to receive voice messages from the Practice and its affiliates containing health information at the home and/or mobile phone numbers on file with the Practice.

I consent to receive email communications from or on behalf of the Practice and its affiliates at the email address on file with the Practice. I understand that these communications may include (but are not limited to) operational notices about my account and insurance and are part of my relationship with the Practice I also understand that these communications may include promotional communications, including, but not limited to, newsletters, information about new services or suggested screenings, specials offers, surveys and other news and information that the Practice thinks will be of interest to me. I understand that I may opt out of receiving promotional emails at any time by following the unsubscribe instructions provided therein. I understand that if I opt out of receiving promotional communications from the Practice, I may still receive transactional communications, including emails about my account or relationship with the Practice.

I permit the Practice to share appointment, billing, and general dental/health information with the following individual(s) who are involved in my (or, if i am the patient's personal representative, the patient's) care (e.g., a family member, friend, caregiver):

I understand that I may revoke any of the above consents at any time by advising the Practice in writing. My revocation of any consent will not affect my (or, if I am the patient's personal representative, the patient's) ability to receive services from the Practice

**Patients Signature/Guardian Signature:**

\_\_\_\_\_ Date: \_\_\_\_\_