BERNARDO CALDAS
ORTHODONTICS

HIPAA ACKNOWLEDGMENT & COMMUNICATION CONSENT

PATIENT PRIVACY & COMMUNICATION

PATIENT INFORMATION

Patient name

Date of birth

Parent / guardian (if applicable)

HIPAA ACKNOWLEDGMENT

I acknowledge that I have received, or have been given the opportunity to receive, a copy of Bernardo Caldas Orthodontics' Notice of Privacy Practices. I understand how my protected health information may be used and disclosed for the purposes of treatment, payment, and healthcare operations, as described in the Notice.

☐ I acknowledge receipt of (or the availability of) the Notice of Privacy Practices.

COMMUNICATION CONSENT

I authorize Bernardo Caldas Orthodontics to communicate with me (and, if applicable, my parent/guardian) regarding appointments, treatment, and account information. I understand that these communications may be made using the contact information provided below, including by phone, voicemail, text message, email, or other means.

PREFERRED COMMUNICATION METHODS

Please indicate how you prefer we communicate with you:

☐ Phone Call ☐ Voicemail ☐ Text Message ☐ Email

CONTACT DETAILS

Preferred phone

Alternate phone

Email address

AUTHORIZED CONTACTS

Please list individuals (e.g., parent, guardian, spouse, or other) with whom we may discuss appointments, treatment, and financial matters related to your care.

Name

Relationship

Name

Relationship

Name

Relationship

APPOINTMENT REMINDER PREFERENCE

How would you like to receive appointment reminders?

☐ Text Message ☐ Email ☐ Phone Call ☐ No Preference

SIGNATURE

By signing below, I confirm that I have read and understand this HIPAA Acknowledgment & Communication Consent form and agree to the terms outlined above.

Patient / parent / guardian signature (type full name)

Printed name

Relationship to patient

Date