Glen E. Mueller, D.M.D., M.A.G.D.
Stephanie A. Wood, D.M.D.

A Family Dental Practice

13096 Tesson Ferry Rd.
St. Louis, MO 63128
Phone: (314) 842-0060
Fax: (314) 842-0067

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize Stephanie A Wood to contact you and how you wish to be contacted (check all that apply):

	ORDER OF PREFERENCE:	OK TO LEAVE VOICEMAIL?	PHONE NUMBER:
HOME PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
CELL PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
WORK PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
ALTERNATE PHONE	☐1 ☐2 ☐3 ☐4 ☐5	☐YES ☐NO	
PATIENT PORTAL & SECURE EMAIL	☐1 ☐2 ☐3 ☐4 ☐5	EMAIL ADDRESS:	
☐ None of the above			

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Primary Care of Cedar Hill to disclose your PHI to the following individuals (check all that apply):

Name: ______________________ **Relationship to Patient:** ______________
Telephone: (______)______________ **Email:** ______________________
Types of Information: ☐ Appointment Reminders ☐ Results (lab test, X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

Name: ______________________ **Relationship to Patient:** ______________
Telephone: (______)______________ **Email:** ______________________
Types of Information: ☐ Appointment Reminders ☐ Results (lab test, X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

Name: ______________________ **Relationship to Patient:** ______________
Telephone: (______)______________ **Email:** ______________________
Types of Information: ☐ Appointment Reminders ☐ Results (lab test, X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

☐ **None of the above** **Signature/Date:** ______________________

Glen E. Mueller, D.M.D., M.A.G.D.
Stephanie A. Wood, D.M.D.

A Family Dental Practice

13096 Tesson Ferry Rd.
St. Louis, MO 63128
Phone: (314) 842-0060
Fax: (314) 842-0067

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information. amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Name of Patient ______________________

Signature of Patient/Date Signed ______________________

Name Patient's Personal Representative ______________________

Signature of Patient's Personal Representative/ Date Signed ______________________

FOR INTERNAL USE ONLY

Name of Employee ______________________

Signature of Employee ______________________

If applicable, reason patient's written acknowledgment could not be obtained: D

- ○ Patient was unable to sign.
- ○ Patient refused to sign.
- ○ Other:

Version 1 Effective Date: 2/1/2018

Notice of Privacy Practices (NPP) Acknowledgement

Fo

Insert additional Patient Information as needed.

Cr

d 1/18/2018