Wakham Orthodontics, PA

wakhamorthodontics.com

ACKNOWLEDGEMENT OF RECEIPT OF OUR PRIVACY NOTICE

I, ____, have received a copy of ***Notice of Privacy Practices*** from Wakham Orthodontics, PA.

Date: ______________________

Print Patient Name: ____

Signature Name/Legal Guardian: ____

You may refuse to sign this acknowledgement.

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Date: ______________________

Print Patient Name: ____

I have given Dr. M. Dean Wakham, DMD, MS and Wakham Orthodontics, PA permission to communicate verbally with my dental or medical providers about my dental findings, medical health, insurance issues, and/or billing information.

Signature Name/Legal Guardian: ____