Holistic Dental Arts Center
Ayman Zraiqat, DDS, COT, IABDM, FAAO
1401 N. Tustin Ave, Suite #345
Santa Ana, CA 92705

Phone: 949-748-0673
Website: HolisticDentalArts.com

Acknowledgement of Receipt of Notice of Privacy Policies
(Adult)

Your Privacy Is Important to Us!

I have received a copy of the Notice of Privacy Practices of Holistic Dental Arts Center. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

I am aware that my information is stored electronically. Although Holistic Dental Arts Center takes necessary precautions and use up-to-date software, there is potential for unauthorized electronic disclosure of PHI. I understand that at times the dental practice may choose to communicate with me electronically at the email address listed below or listed on the health history form. **I am aware that there is some level of risk that third parties might be able to read unencrypted emails.** I am aware that information sent by email at this time is non-encrypted and give my consent. (HB 300 Tx Health & Safety Code Sec 181.154)

_____ _____
Print Name

_____
Address

_____ _____
Signature Date

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number _____
- ☐ You may contact me on my mobile telephone number _____
- ☐ You may contact me on my work telephone number _____
- ☐ You may leave a message on my answering machine regarding my appointment time _____
- ☐ You may send me an email at: _____
- ☐ Text, other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____
2. _____ Date Added / Removed: _____
3. _____ Date Added / Removed: _____

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Patient Consent

Clinical

1. I authorize Holistic Dental Arts Center to perform all recommended treatment as explained.
2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.

Financial

3. I am responsible for payment for all services rendered on my behalf.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: _____ Date: _____

Patient's 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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____