**Cynthia Creech, D.D.S.**

**Authorization to Contact Patients via cell phone**

As of July 1, 2015 and in accordance with HIPAA Privacy laws and Federal Communications Commission guidelines all dental practices are required by law to receive prior authorization to contact patients via the patient’s cell phone with regards to any account information, including insurance and billing. Your signature below authorizes our office to contact you via cell phone when deemed necessary with questions regarding your account and/or insurance.

**­­­­­­­­­­­Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPAA Privacy Practices and Acknowledgement**

**I have received a copy of Dr.Cynthia Creech’s Notice of Privacy Practice for review.**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 acknowledgement

\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*You may refuse to sign Privacy Practices Acknowledgement\*