HARBOR kids' TEETH
BOARD CERTIFIED PEDIATRIC DENTIST
LISA A. BLOCK, DMD, MS

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(253) 858-8581 FAX: (253) 858-2189

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), we are notifying you of our most updated "Notice of Privacy Practices" which explains how our office may use Protected Health Information about you or a patient for whom you are responsible for. This means we may send information including demographic or billing information that may individually identify you or the patient and that relates to past, present or future health condition and related health care services and payment for the purpose of treatment and billing. Our complete privacy practice policy is on display in our reception area. We appreciate your time in completing this document.

I, _____ , the parent/legal guardian (please circle)

of _____

_____

Acknowledge that I have reviewed a copy of the "Notice of Privacy Practices" from Lisa A. Block, DMD, MS and Harbor Kids' Teeth. I further acknowledge that a copy of the current notice is posted in the reception area.

SIGNATURE:_____ DATE:_____

CONSENT TO RECEIVE PHONE CALLS

In accordance with The Telephone Consumer Protection Act of 1991 (TCPA) and health insurance portability and Accountability Act (HIPAA), we may send information including protected health care information, demographic, or billing information that may individually indentify you or the patient and that relates to past, present, or future health conditions and related health care services and payment for the purpose of treatment and billing. Our complete privacy practice policy is on display in our reception area. We appreciate your time in completing this document.

I, _____ , the parent/legal guardian (please circle)

of _____

_____

consent to receive calls and text from Lisa A. Block, DMD, MS (Harbor Kids' Teeth) or companies acting on behalf of Lisa A. Block, DMD, MS for the protected healthcare information, accounting and other services of mine and the above listed patient (s) at the phone number(s) below, including my wireless number which my agent or I have provided. I understand that I may be charged for such call and texts by my wireless carrier and that such calls may be generated by an automated dialing system.

HOME_____ CELL:_____ WORK: _____

SIGNATURE:_____ DATE:_____

FOR OFFICE USE ONLY Account#: _____