Patient Name: ____ **Date:** _____________________

CONSENT FOR ELECTRONIC COMMUNICATION

You may consent to receive e-mail and/or text messages from us regarding your treatment. By agreeing to receive electronic communication from our office, you understand there is some risk that any individually identifiable health and other confidential information that may be contained in such an e-mail or text message may be misdirected, disclosed to, or intercepted by unauthorized third parties. All electronic communications from our office to you will be sent from our secured, encrypted server.

Information that can be sent electronically includes but is not limited to appointment reminders, treatment plan information, estimates of cost, account payments, insurance information, specialist referrals. We will notify you prior of any personal information being shared electronically.

I consent and accept the risk in receiving information electronically. I understand that I can withdraw my consent at any time. I further agree that I am responsible for providing Trinity Smiles any updates to my e-mail address and/or phone number. **YES□** **NO □**

If YES, please provide your preferred method of electronic communication: **TEXT □** **EMAIL□**

Phone Number for Text ____

E-Mail Address ____

Patient Initials ______________

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Trinity Smiles to disclose Protected Health Information (PHI) to the persons specified on this form. Private information we may disclose includes account information, treatment information, appointments, etc.

Name ____ **Relationship** _________________________

Name ____ **Relationship** _________________________

Patient Initials _______________

AUTHORIZATION FOR SIGNATURE ON FILE

I hereby authorize Trinity Smiles to affix my name to all claims or documents related to any medical benefits due to me or my dependents and authorize payment of insurance benefits directly to Trinity Smiles, otherwise payable to me. I agree to be responsible for all charges for dental services not paid for by my insurance carrier or dental benefits payer. To the extent permitted under applicable law, I authorize release of any information related to dental claims. This “Signature on File” will be valid from this date forward.

Patient Initials: _______________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Included with New Patient Forms)

I acknowledge that I have been provided a copy of the Trinity Smiles Notice of Privacy Practices, which describes how my health information is protected and how it may be used and disclosed.

Patient Initials: _______________

Please contact our office at (972) 696-0516 or info@trinitysmilesdental.com for any questions