**Acknowledgement of Receipt of Privacy Practices**

\*You may refuse to sign this acknowledgement

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been informed of the Privacy Practices for Dr Alice Johnson’s office.

The following individuals may receive or provide information regarding my diagnoses and dental treatments.

These same persons may receive or provide information regarding billing, payment, or insurance coverage. Yes\_\_\_\_\_ No\_\_\_\_\_

Email sent to [staff@alicejohnsondds.com should](mailto:staff@alicejohnsondds.com%20should) not be used for confidential issues as we cannot guarantee the security of any information you send to us using email. Email should be for general topics and questions only. Response will be given as soon as possible and generally within 1-2 business days.

I grant permission for Dr Johnson’s office to use email when necessary to communicate regarding appointments and topics of general interest.

Yes\_\_\_\_ No\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_