Carrie K. York, DDS

Family and Cosmetic Dentistry

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COMMUNICATION CONSENT FORM

Name: _____ Date of Birth: _____

Dr. Carrie K. York DDS, PLLC wants to make sure your personal information is private.

You have the right to keep your health information private except as required or permitted by law.

- You have the right to tell us how you want to be contacted
- You have the right to tell us with whom we may speak with about your health, appointments, treatment, billing and insurance.

Whom may we contact about your health, appointments, treatment, billing and insurance?

***Please circle your preferences

Name: _____ Relationship: _____ Phone: _____

Health Information Appointments Treatment Billing Insurance

Name: _____ Relationship: _____ Phone: _____

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Health Information Appointments Treatment Billing Insurance

Name: _____ Date of Birth: _____

I give consent to Dr. Carrie K. York, DDS and her team to contact me electronically by email address and/or cell phone for the purpose of receiving appointment reminders, notification that I need to make an appointment, reminders of uncompleted treatment, insurance questions, billing and account questions, experience surveys and pre-medication reminders (if applicable), etc.

I understand that during the transmission of these messages, the information contained at one point or another may pass through a public network and onto a personal electronic device and as such the transmission may not be secure. However, the practice will not transmit any personal or confidential information about your health, procedures or account status without your permission. Please note that email messages from our office are encrypted messages sent through SendIt Secure and we use a secure 3rd party service for text messages.

I agree to inform the office if my email address or cell phone number changes.

Email Address (please print CLEARLY): _____

Cell Phone Number: _____

If you would **NOT** like to be contacted by secure email or text message you may **OPT OUT** of one or both by initialing below. You may change your elections at any time by contacting the office.

_____ I elect to **OPT OUT** of secure EMAIL messages

_____ I elect to **OPT OUT** of secure TEXT messages

*****If you choose to OPT OUT of electronic communications, what is the best way to contact you?***

Primary Phone: _____

Secondary Phone: _____

Patient Signature: _____ Date Signed: _____