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Excellence in Oral & Maxillofacial Surgery, LLC

_____/_____/_____
Today's Date (Effective Date)

I, _____, hereby acknowledge that I have read this practice's ***Notice of Privacy***
(Print Patient's Name)

***Practices*.** I have been given the opportunity to ask any questions I may have regarding this notice.

NOTICE: According to HIPPA confidentiality regulations there will be NO CELL PHONE USE ALLOWED in the patient care areas. This includes phone calls, photos, videotaping and recording. Thank you for your cooperation and respect for our patients and employees' privacy.

_____

Signature of Patient or Guardian **Print Name** **Today's Date**

WITH WHOM MAY WE SHARE YOUR PERSONAL OR FINANCIAL INFORMATION?

NAME	**RELATIONSHIP**
1) _____	_____
2) _____	_____
3) _____	_____

UPDATE:

Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____