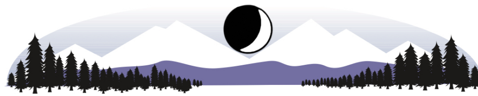

Front Range Dental Sleep Medicine

ANDREW T SMITH, DDS

SPECIALTY TRAINED DENTIST: PRACTICE RESTRICTED TO
INTRAORAL APPLIANCE THERAPY FOR SLEEP APNEA & SNORING
OROFACIAL PAIN, TEMPOROMANDIBULAR JOINT DISORDERS (TMJ) & RELATED HEADACHES

NOTICE OF PRIVACY PRACTICES

Patient Name:____ Date of Birth:______________

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) this office may use your personal health information for the purpose of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices prior to signing the consent form. You may request restrictions on the "restriction request" form, which we will provide if needed. You may revoke this consent at any time by signing and dating the revocation form, which we will provide if needed.

ACKNOWLEDGEMENT / CONSENT OF NOTICE OF PRIVACY PRACTICES

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations. I also acknowledge that I am informed of Dr. Smith's Practice Privacy Policy and have been offered a copy.

____ _______________________

Signature of patient or patient representative Date

COMMUNICATION REQUEST

The phone numbers listed below are the only place(s) my personal health information may be left as a message or as voicemail. This includes appointment times, results of testing, insurance status and/or any other personal communication that needs to take place that may contain personal health information and is a part of my healthcare in this office.

Phone Number	Location (circle one)
______________________________	Home Work Cell Phone Pager Other
______________________________	Home Work Cell Phone Pager Other
______________________________	Home Work Cell Phone Pager Other

____ ______________________________

Signature of patient or patient representative Date

Additional Communication

I give my permission for medical information to be discussed with:

☐ Parents (if under 18) ☐ Spouse/Partner ☐ Other: ______________________

____ ____________________________

Signature of patient or representative

8400 E. Prentice Avenue, Suite 804, Greenwood Village, Colorado 80111

Phone: 303-770-3300 Fax: 303-804-0500 Website: denverofp.com

Email: asmithsleepdds@gmail.com