Bayview Dental

420 Grand Ave, Center City, MN 55012

Notice of Privacy Practices Acknowledgement Form

Patient's Name: (First Name, Last Name):	Date of Birth:
Patient's Address:	
Patient's Phone Number:	

I understand that as part of my dental care, Bayview Dental creates and maintains health records that describe my health history, dental information, symptoms, examinations, test results, diagnosis, procedures, treatment, and plans for future care or treatment I may receive. I understand that health information collected and stored will be used for the following:

- To support my care and treatment at Bayview Dental (treatment)
- For continued treatment among health professionals who are involved and contribute to my health care (treatment)
- For billing purposes including information regarding my diagnosis, treatment, and services rendered (payment)
- For insurance claim processing by a third-party payers for verification of services billed (payment)
- A tool for routine healthcare operations such as assessing quality improvement (healthcare operations)

I understand that the Notice of Privacy Practices from Bayview Dental defines more information regarding the use and disclosure of my protected health information as well as my rights to my health information. By signing this, I acknowledge that Bayview Dental has offered me a copy of their Notice of Privacy Practices. I acknowledge and understand the rights that I have over my protected health information. I authorize the use and disclosure of my protected health information as specified in the Notice of Privacy Practices. I authorize the use and disclosures for treatment, payment, and healthcare operations purposes for Bayview Dental.

I understand that I am ultimately responsible for all charges incurred for dentistry performed at Bayview Dental office including balances left after insurance payment has been received.

I understand that Bayview Dental communicates through text messaging about appointment reminders that contain patient specific information. I agree to the communication through text messaging unless I opt out.

This consent will continue forever unless I cancel it by writing to: Bayview Dental, 420 Grand Ave, Center City, MN 55012; if the consent is cancelled, it will not change releases that have already been made prior to the date of cancellation.

I understand that I can get an electronic copy of the Notice of Privacy Practices at www.bayviewdentalmn.com.

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Patient's Signature/Legal Representative Signature Date (MM/DD/YYYY)

If Legal Representative, relationship to Patient (parent, guardian, ect) _____