Patient Consent / Acknowledgment Form

By signing below, you consent to the use and disclosure of your protected health information by D. Kelly Wilfong, D.D.S., PLLC, our staff and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notices"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at 304-424-7343 and requesting a revised Notice. We will also post a revised Notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you chose to refuse to disclose your Protected Health Information (PHI).

For our adult patients, records retention will be 7 years from the date of your last visit. For minor patients, this will be 7 years from the age of 18. Patient's that are mentally or physically disabled, records will be kept indefinitely.

This form is also used to obtain acknowledgment or receipt of OUR NOTICE of privacy practices or to document our good faith effort to obtain that acknowledgment.

In case we need to contact you, should we call: (circle preferred phone number)

Home ____________________ Cell ______________________ Work ___________________________

Do you authorize us to leave messages at your preferred phone number(s)? YES NO

Would you like us to send you text message reminders for appointments? YES NO

Would you like us to send you email reminders of appointments? YES NO

If yes, best E-mail address: ____

With whom do you authorize us to speak with concerning your treatment?

____

I have reviewed, understand and agree to the content of the Notice of Privacy.

Print Name: _______________________________________ Date: ____________________

Signature: ____________________________________