

Facial Spectrum, Inc.
1208 NE Windsor Drive
Lee's Summit MO 64086

I, _____, hereby acknowledge that I have received a copy of Facial Spectrum
Patient Name
Inc.'s *Notice of Privacy Practices*. I have been given the opportunity to ask any questions I may have regarding this
Notice.

Signature of Patient (if patient under age 18, Date
Parent or Legal Guardian must sign)

Print Name Date

Relationship (if not patient)

I prefer to be contacted in the following manner (*check all that apply*):

- Home Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only
- Cell Phone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only
 - O.K. to send text message with detailed information (texting fees may apply)
- Work Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only
- Written Communication
 - O.K. to mail to my home address
 - O.K. to mail to my work/office address
 - O.K. to fax to number indicated
- Other (Spouse/parent work phone cell, etc.) _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only
- E-mail _____
 - O.K. to send message with detailed information
 - Send message with call-back number only

I allow you to give my clinical information to or answer questions from (*check all that apply*):

- Spouse _____
- Parent _____
- Child _____
- Other (specify): _____
- All referring doctors; including general dentist, endodontist, primary care physician / specialist
- None