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, Parent or Legal Guardian must sign**) Date

_____ _____
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