# West Metro Pediatric Dentistry Authorization/Acknowledgement Form

*If you have any questions about any part of this, please let us know and we will be happy to clarify.*

Child's name: _____ Date of Birth: _____
Child's name: _____ Date of Birth: _____
Child's name: _____ Date of Birth: _____
Child's name: _____ Date of Birth: _____

**Authorization to Communicate Via E-mail**

I authorize West Metro Pediatric Dentistry to communicate with me via e-mail, which may be standard/unencrypted email, with information regarding appointments, billing notifications, and/or practice updates. These emails may include health information about myself and/or my child, as well as information about any insurance holders on our account.

Email address for our account: _____

**Acknowledgment of Review of Notice of Privacy Practices, and Financial Policies, and Appointment Policies**

I, as the legal guardian of the child/children listed above, have reviewed a copy of this office's Notice of Privacy Practices, and also a copy of this office's Financial Policies, and also a copy of this office's Appointment Policies. I understand the information included in these policies. I am aware that I may request a paper or electronic copy of these policies at any time for my records.

Legal Guardian Printed Name: _____ Relationship: _____

Legal Guardian Signature:_____ Date:_____

***For Office Use Only:*** *We attempted to obtain written acknowledgement/authorization of the above, but this could not be obtained because:*

- ☐ *Individual refused to sign*
- ☐ *Communications barriers prohibited obtaining the acknowledgement*
- ☐ *An emergency situation prevented us from obtaining acknowledgement*
- ☐ *Other (Please Specify):* _____