NORDHUS DENTISTRY, LLC

Consent & Acknowledgment

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

We reserve the right to change our privacy practices as described in Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice, which will contain the changes. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person:	*Nordhus Dentistry*
Telephone:	*(316) 721-6730*
Address:	*11940 W. Central, Ste. 100 Wichita, Ks. 67212*

I have received a copy of this office's Notice of Privacy Practices with the effective date April 14, 2003. I am giving my consent to this office to use and disclose my protected health information to carry out treatment, payment activities, and health care operations.

_____
(DATE)

_____
(PATIENT NAME – PLEASE PRINT)

_____
(SIGNATURE OF PATIENT OR LEGAL GUARDIAN)

Documentation of Good Faith Efforts

We attempted to obtain written consent & acknowledgement to our Notice of Privacy Practices, but were unable to obtain because:

- ☐ Patient refused to sign
- ☐ Patient was unable to sign because:
  _____
  _____
  _____
- ☐ An emergency situation prevented us from obtaining
- ☐ Other (described below):
  _____
  _____
  _____