Coral Springs Oral Surgery

2801 N University Drive #102

Coral Springs, FL 33065

**ACKNOWLEDGEMENT OF RECIEPT OF HIPAA NOTICE OF PRIVACY POLICY PRACTICES**

I acknowledge that I have received a copy of this dental practice HIPAA notice of privacy practices.

**Authorization to release medical info if needed.**

This signature on file is my authorization for the release of any medical information / records required by Dr. Laith Azzouni to obtain clearance for my surgical procedure done at Coral Springs Oral Surgery.

**Policy on Payment**

Coral Springs Oral Surgery may, at its option, impose $15 late fees on a monthly basis for up to three months should unpaid invoices remain open for more than thirty (30) days. The last fee gets added to your remaining balance.  For example, if your balance due is $100.00 and it remains unpaid for over 90 days your new remaining balance will become $145. After 90 days, your account becomes eligible to be placed with a third-party collection agency.

**Cell Phone Use**

Cell Phone Calls/Text and Emails. By providing your cell phone number and/or email address, you consent to receiving such calls or electronic communications at the number or email address provided, including but not limited to, communication attempts (calls, text messages, emails or other electronic means) made by automated telephone dialing system, prerecorded messages or artificial voice. This consent is for Provider and any affiliates, including any and all third-party entities hired by Provider for billing, collections, or customer care services. With your permission, we can provide you with electronic versions of documents associated with your account(s) at provider rather that in paper form. The documents include notices, disclosures, records and other information in connection with any of your current or future account(s) at provider affiliates, including any and all thirst party entities hired by provider for billing, collections or customer care services. Providing consent does not mean that we will provide all documents electronically, but that we may provide electronic versions in accordance with your preferences. Electronic documents will be delivered to you via email at the email address provided by you.

I consent to receive SMS text messages from Coral Springs Oral Surgery for appointment reminders,

marketing messages, and general two-way communication. Msg frequency varies. Msg & amp; data

rates may apply. Reply HELP for support. Reply STOP to opt out. Refer to our website: [www.coralspringsoralsurgery.com](http://www.coralspringsoralsurgery.com) for our privacy policy and for more information.

I provide consent for Coral Springs Oral Surgery dental practice to use my cell phone number to (choose one or both)

Call

Text

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name (Please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_