PATIENT PRIVACY

_____Due to all the new patient privacy acts that have gone into effect it has become necessary to have you read and initial the following. Dr. Wagner and his staff will do their best to ensure y our privacy while in our office.

_____I understand that when I sign in at my arrival that another patient may see my name on the sign in sheet.

_____I understand that someone may see my name on the schedule on the computer but there is no personal information on that screen for anyone to see.

_____I understand that it might be necessary to call out my name in the office in order to get my attention.

_____I understand that another dental office or medical office may have information that is pertinent to my care and treatment at Dr. Wagner's office and I authorize Dr. Wagner or a member of his staff to request that information, including x-rays, written notes, models, etc.

_____I understand that Dr. Wagner's office will call me regarding my appointments. I authorize Dr. Wagner or his staff to leave a message with someone or a recorded message at the phone number(s) I have provided.

_____At times it will be necessary to have my file out and another patient may see my name, but my file will never be left where another person can read its contents.

_____If I am speaking with the doctor or a member of his staff, I will ask for a private room if I don't want the conversation to be heard by others in the office or waiting room.

_____I agree to all the above statements and understand that any information regarding my treatment will be guarded as much as possible and will not be revealed to another patient.

SIGNED:_____DATE:_____