



Consent for Internet Communication/PHI

Bearden Family Dental uses a new software called Patient Portal, which is similar to the portal used by your medical Doctor & most hospitals. It will permit you to access your appointment times and allow you to update your information. Most offices use this form of electronic conformation and delivery of your statements, we also have the option to text a link to your cell phone. Please carefully read the information below on how you want this communication. I also understand that State and Federal laws, as well as ethical and licensure impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to a third party. I understand the dental practice will represent and warrant that they will at all times, during the term of this agreement and thereafter, comply with all laws directly and indirectly applicable that may now hereafter govern the gathering use, transmission, processing ,receipt, reporting disclosure maintenance and storage of my information , and use their best efforts to cause all persons or entities under the direction or control to comply with such laws . I agree that the dental practice has the right to monitor and retrieve, store, upload and use my information in connection with the operation of such services and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice **CANNOT AND DOES NOT ASSUME ANY RESPONSIBILTY FOR MY MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPOADED OR RECEIVED USING THE SITE OR SERVICES.** I grant my permission to Bearden Family Dentistry to upload and store confidential patient information (including account information, appotiment information and clinical information) to the secure website for Bearden Family Dentistry. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand that Bearden Family Dentistry and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered because of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, the disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID and password or any other need to deactivate my ID due to security concerns. By signing the form below, you are stating that you have read and fully understand the information above regarding the secured uploading of patient information to the website for the dental practice and grant the dental practice permission to securely upload my patient information to the Patient Portal. By signing below, you consent to receive text, email confirmations for reminders or upcoming appointments unless otherwise stated below. I hereby acknowledge that a copy of this office’s Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. From time to time, we may need to reach you regarding scheduling, billing in the event we cannot reach you please list below who we may leave a message with.

- I do not wish to receive any type of electronic communication or invite to the Patient Portal.**
- I wish to receive electronic communication of reminders, monthly statements, and Patient.**

| How do you want to receive | Text, please list # below | Email |
|----------------------------|---------------------------|-------|
| Appointment Reminders: | | |
| Monthly Statements: | | |
| Text To Pay #: | | |

| Who May We Speak With | Relationship | Phone # |
|-----------------------|--------------|---------|
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| | | |

Signature Of Patient Or Guardian _____ Date _____

Print Name: _____