WEST CHESTER
CENTER FOR DENTISTRY
• • •
At University Pointe

You have requested that our practice communicate with you electronically via email, text, and phone. By utilizing our practice's electronic services, you agree that ***West Chester Center for Dentistry*** may send to you any of the following that you identify as communication that can be sent through the internet to an email address you designate.

Consent and Acknowledgement

I_____, in the presence of my dentist or the dental practice's privacy official, agree that the practice may electronically communicate with me at the following email address.

Email Address_____

Patient's Date of Birth (for verification purposes)_____

I acknowledge that the practice may send the following to my email. Check each that apply, and then provide your initials at the end of each item selected.

- o Information about my invoice or accounts payable. _____(initials)
- o Information about a specific dental visit. _____(initials)
- o Information about any dental visit. _____(initials) Specify_____

Acknowledgement

You must acknowledge each of the following before we can send communication electronically.

_____All electronic communications from our practice will be encrypted.

_____I am responsible for providing the dental practice any updates to my email address.

_____I am able to receive information electronically and store it securely away from any public computer.

_____I can withdraw my consent to electronic communications by calling 513-759-4485.

Patient's Signature_____Date _____

7798 Discovery Drive, Suite D • West Chester, OH 45069
Tel 513.759.4485 • Fax 513.759.4468
www.wccdentistry.com