Patient Communication Policy

It is important to note that standard email and text communication is not always secure. Email and text messages can be intercepted and for this reason, our practice does not communicate personal health information through this method. Our Practice will never ask for account information, credit card numbers, or personal information via email or text message. If you think you may have received a suspicious email or text from our practice , please contact our office immediately at:

Rosalyn L. Burke, DDS, PC

FAMILY, COSMETIC, AND IMPLANT DENTISTRY

3600 Concord Blvd, Concord, Ca 94519 T: (925) 448-3770

Email Appointment Confirmations

By enrolling in email appointment confirmations, you may receive non-appointment related emails throughout the course of your subscription with our office. Emails may include special offers for your specific location or alerts notifying you about important office news and events.

At this time, if you subscribe to receive email appointment confirmations, you automatically are subscribed to receive any marketing-related email. We promise that we will not spam your account with unnecessary emails, nor will we sell your information to a third party.

Text Appointment Confirmations

By enrolling in text appointment confirmations, you are authorizing our office to send text message appointment reminders to you on your provided cell phone number. You understand that you may reply with various commands to receive account information such as balances, future appointments, office location and other alerts

You also agree that all individuals associated with your account may receive alerts referencing the account guarantor and/or dependents. Text message charges from your cell phone provider may apply.

Your enrollment indicates that your represent and warrant that you are the person legally responsible for all use of the accounts, are at least 18 years of age, and agree to all terms and conditions of use for the text messaging services.

Email To Other Doctors

Upon written request from you, we may release x-rays and treatment information to other practices and/or specialists on your behalf. Please note that all email communications from this office are sent using a secure, encrypted email program and the receiving practice will be prompted to create a username and password to securely access your records. Some offices may wish to not utilize this secure portal, in which case, a printed copy of your records can be mailed to their practice.

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Patient Consent for Electronic Communication

Our office utilizes the convenience of email. By using our practice's electronic services, you agree that our office may send to you any of the following that you identify as a communication that can be sent through the internet to an email address you designate. All electronic communications from our practice to you will be sent from our secured, non-encrypted email server.

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is: _____

☐ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My cell phone number is:_____

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

_____

Name Date

Consent for Leaving Messages

I understand that my healthcare information is protected. I understand that, in order for us to leave detailed messages containing specific dental information on my voicemail or answering machine, I need to give permission for us to do so.

I give permission for messages to be left on my phone number(s) below:

☐ Cell # _____ ☐ Work # _____

☐ Home # _____ ☐ I prefer to not have voicemail messages

Regarding the following:

☐ Appointment Reminders/Changes ☐ Cost Estimates

☐ Account Payments/Balances ☐ Needed Treatment/Completed Treatment

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Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for **Dr. Rosalyn Burke** and representatives at our practice to verbally discuss my care using their best judgment and grant them permission to disclose dental information that is relevant to my care or relevant for payment.

	Name	Relationship	Phone Number
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

Regarding the following:

☐ Appointment Reminders/Changes

☐ Account Payments/Balances

☐ Cost Estimates

☐ Needed Treatment/Completed Treatment

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

_____

Printed Name (Patient/Parent) Signature (Patient/Parent) Date

