Philip C. Wilkins, DMD, PC
Reid P. Warren, DMD
124 N. Congress Street • Winnsboro, SC 29180
(P) 803-635-6162 • (F) 803-635-1780

Notice of Privacy Practices Acknowledgement

I have received and had the full opportunity to read a Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information (PHI) to carry out treatment, payment activities, and health care operations.

Patient Signature / Legal Guardian _____ Date _____

Additionally, you can disclose my PHI to the following recipient(s):

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Electronic Communications

In order for us to service your account, primarily for appointment reminders and billing/collection efforts, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us.

I have read this disclosure and agree that the office of Dr. Philip C. Wilkins and Dr. Reid P. Warren or their representative may contact me as described above.

Patient Signature / Legal Guardian _____ Date _____

Consent to Access Pharmacy Information Electronically for Medical Treatment

The office of Dr. Philip C. Wilkins and Dr. Reid P. Warren currently participates in an electronic prescription service. This program allows for the electronic prescribing of medications, which provides a convenience to both patients and physicians, and also reduces medication errors. In addition, this service allows for the electronic receiving of information such as names and dosages of prescriptions filled at participating pharmacies. This allows us to reduce errors in medication entries into your medical record and provides the dentist with your up-to-date medication profile.

My signature below signifies that I have read and understand that I am authorizing the staff of the office of Dr. Philip C. Wilkins and Dr. Reid P. Warren to access my PHI through electronic prescription service for the purpose of updating my medical records prescription information. Additionally, I understand that this permission may be revoked at any time.

Patient Signature / Legal Guardian _____ Date _____