



Claus Orthodontics Photo Authorization

I authorize Claus Orthodontics to post facial photos in areas of the office, which are open to public display. I also authorize placement of facial photos with use of name, treatment information, and quote about my orthodontic outcome online on www.claussortho.com and on the Claus Orthodontics social media page(s), which are open to public display. I understand it is my right to refuse this or request that such above mentioned be removed at any time.

Patient Name (Printed): _____

Signature of Patient (or Parent/Guardian if under 18)

Date

Privacy Practices Documentation (HIPAA)

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name (Printed): _____

DOB: _____

Signature of Patient (or Parent/Guardian if under 18)

Date

----- For Office Use Only -----

Written acknowledgement could not be documented due to:

- Patient refused to sign
- Personal representation not available to sign
- Language, communication, or effects of disability impeded acknowledgement
- Other, please specify _____