Notice of Privacy Polices

Last Name: _____ First Name: _____ Birthdate: _____/_____/_____

Date: _____

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

I give my permission to Aghbashian Dental Corp., represented in Dr. Nova Aghbashian to contact the following individuals on my behalf, in regards to:

☐ Billing and Insurance Issues

☐ Medical Issues

☐ Both

Name: _____

Name: _____

Name: _____

Patient Signature_____

Aghbashian Dental Corp.
1000 N. Central Ave. suite 130
Glendale, CA 91202

Office Phone: (818) 242-8892
Fax: (818) 242-2650
Email: info@novabrightdental.com