Just for Your Smile

Sam Osseiran, D.D.S., M.S., M.A.G.D.

Consent to Use Electronic Communications

First Name:_____Last Name: _____

Address:_____City:_____State:_____Zip:_____

Email (if applicable):_____

Phone (as required for Service(s)):_____

The dentist has offered to communicate using the following means of electronic communication ("the Services")

[check all that apply]:

- ☐ Email
- ☐ Videoconferencing (including Skype®, FaceTime®)
- ☐ Text messaging (including instant messaging)
- ☐ Website/Portal
- ☐ Social media (specify):
- ☐ Other (specify):

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the Physician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted.

Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk. I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through the Services upon providing written notice. Any questions I had have been answered.

I have reviewed and understand all of the risks, conditions, and instructions described in this Appendix.

Patient Signature_____ Date_____