PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims.

Date: ___________________

The undersigned acknowledges the current effective Notice of Privacy Practices for Drs. Heringhaus General Dentistry. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILTY IN THE FUTURE.

______________________________ ______________________________

Please print patient name Signature of Patient/Guardian

______________________________ ______________________________

Parent/Guardian (if patient is a minor) Relationship to patient

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

This includes step parents, grandparents and any care takers who can have access to this patient's records.

All Family Members: _______

Only the Following Individuals:

Name: _______________________ Relationship: _________________________

Name: _______________________ Relationship: _________________________

Name: _______________________ Relationship: _________________________

AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM APPOINTMENTS VIA: (Please **CIRCLE** the **PREFERRED** method)

Cell Phone # Home Phone # Work Phone # Text Message # Email__________________

I AUTHORIZE INFORMATION ABOUT MY TREATMENT OR BILLING INFORMATION BE CONVEYED VIA: (Please circle the preferred method)

Cell Phone Home Phone Work Phone Text Message Email__________________

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS OR NEW HEALTH INFO ON BEHALF OF Drs. Heringhaus General Dentistry via: (Please circle preferred method)

Cell Phone Home Phone Work Phone Text Message Email___________________

Opt Out

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products of services to promote you improved health. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment __
I could not communicate with the patient __
The patient refused to sign __
The patient was unable to sign __
Other (please describe) __

____

Signature of Privacy Officer