

HIPAA OMNIBUS RULE

**PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT/LIMITED AUTHORIZATION & RELEASE FORM**

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

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND 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):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation
- Text Message to my Cell Phone
- Home Phone Confirmation
- Email Confirmation
- Work Phone Confirmation
- Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation
- Text Message to my Cell Phone
- Home Phone Confirmation
- Email Confirmation
- Work Phone Confirmation
- Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS** or **NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- Phone Message
- Text Message
- Email
- Any of the Above**
- None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. 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 RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

Please **print** name of Patient

Please **sign** Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

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 because
- Other (please describe) _____

Signature of Privacy Officer _____

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance benefits. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 45 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must provide proof of insurance at each appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Outside financing is available upon request and approval.

Returned checks and balances older than 45 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Additionally, our office may charge you for broken appointments and appointments cancelled without 48-hour advance notice.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

Print Name

Signature

Date