HIPPA OMNIBUS RULE

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

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

Date:_____

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.

Please print your name. Please sign your name.

_____ _____

Legal Representative Description of Authority

_____ _____

Phone number: Email:

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

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 _____All of the above

In signing this HIPPA 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 HIPPA Omnibus Rule, provide you this information with your knowledge and consent.

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