HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgment & 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, **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 the Patient | Please sign for Patient / Guardian of the Patient

_____ _____

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

Your comments regarding acknowledgements or consents: _____

Appointment Confirmation

I, (Print Parent/Guardian Name) _____, the parent/legal guardian of the aforementioned patient, give consent to the staff members of Smile Wright Dental to leave this patient's appointment information, including name, appointment day, and appointment time, with any persons and/or voicemails of all telephone numbers given on the medical history form, in order to confirm the patient's appointment prior to appointment.

Parent/Guardian Signature _____ Date _____ Phone _____

I authorize contact from this office to **confirm my appointments, treatment & billing information** via:

☐ Cell phone confirmation ☐ Mail confirmation ☐ Text message to my cell phone
☐ Work phone confirmation ☐ Home phone confirmation ☐ Any of the above

I authorize **information about my child's health** can be conveyed via:

☐ Cell phone confirmation ☐ Mail confirmation ☐ Text message to my cell phone
☐ Work phone confirmation ☐ Home phone confirmation ☐ Any of the above

I approve of being contacted about **special services, events, fund-raising efforts, or new health info** on behalf of this health care facility via:

☐ Cell phone confirmation ☐ Mail confirmation ☐ Text message to my cell phone
☐ Work phone confirmation ☐ Home phone confirmation ☐ Any of the above

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 the current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Name _____ Date _____

Office Use Only:

As an Employee, I attempted to obtain the patient's (or representatives) signature of acknowledgment 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 Employee _____ Date _____