Capital Smiles

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND 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: _____

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/FACITILYS IN THE FUTURE.**

_____ _____
Printed Name Signed Name

_____ _____
Legal Representative, if applicable Relationship, if applicable

HOW DO YOU WANT TO BE ADDRESSED WHEN CALLED FROM THE RECEPTION AREA:
□ First Name Only □ Proper Sir Name □ Other: _____

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

Name: _____ Relationship: _____

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

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

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

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to Cell Phone
□ Email 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 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
□ The patient refused to sign
□ I could not communicate with patient
□ Other: _____

Privacy Officer Signature: _____