North Benton Dental Care, P.A.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & 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/FACILITY'S IN THE FUTURE.**

______________________________ ______________________________ ______________

Please **print** your name | Please **sign** your name | Date of Birth

______________________________ ______________________________

Legal Representative | Description of Authority

Your comments regarding Acknowledgements or Consents: ____

____

HOW WOULD YOU LIKE TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

___ First Name Only ___ Proper Surname ___ Other ______________________

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I GIVE CONSENT FOR THE OFFICE TO SPEAK TO THE FOLLOWING INDIVIDUAL(S) AND THE INFORMATION TO BE RELEASED:

Name: ____________________________ Relationship: _________________________

___ Treatment ___ Diagnosis ___ Schedule ___ Payment ___ Other ________________

Name: ____________________________ Relationship: _________________________

___ Treatment ___ Diagnosis ___ Schedule ___ Payment ___ Other ________________

Name: ____________________________ Relationship: _________________________

___ Treatment ___ Diagnosis ___ Schedule ___ Payment ___ Other ________________

- -

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**

Email: _________________________________ Cell Phone: _____________________________________

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.

I understand that when appropriate, credit bureau reports may be obtained.

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Office Use Only

We, one or more of the Business Team attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____ The patient was unable to sign because _____ ________________________________

We could not communicate with the patient _____ Other _____ ________________________________

The patient refused to sign _____

______________________________________ ______________

Signature of Business Team Member | Date