HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT

OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You may refuse to sign but, in refusing we will 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 practice, Highlands Ranch Dental Care. A copy of this signed, dated acknowledgement shall be effective as the original.

_____________________________________ _____________________________________

Please print Patient Name Please sign Patient Name

_____________________________________ _____________________________________

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: ____

____

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

__First Name __Proper Surname __Other________________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:

(This includes any care takers, step-parents, grandparents who can have access to this patient's records):

Name:_________________________________ Relationship:_________________________________

Name:_________________________________ Relationship:_________________________________

I AUTHORIZE INFORMATION ABOUT MY HEALTHCARE BE CONVEYED VIA:

__ Cell Phone Confirmation __ Home Phone Confirmation __ Work Phone Confirmation

__ Text Message Confirmation __ Email Confirmation __ Any of the Above

---

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this practice may recommend product or services to promote your improved health.

Office Use Only:

As Privacy Officer, I attempted to obtain the patient's or representative signature on this form, but did not because:
__ Emergency Treatment __ Refused to sign __ Could not communicate w/ patient __ Unable to sign

Signature of Privacy Officer_______________________________________