Dental Associates of Hershey

HIPAA OMNIBUS RULE

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 Dental Associates of Hershey. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

_____ _____

Printed name of Patient Signature of Patient or Guardian

_____ _____

Legal Representative/Guardian Relationship of Legal Rep/Guardian

Your Comments regarding Acknowledgements or Consents:_____

_____

How do you want to be addressed when summoned from the Reception Area:

__First Name Only __Proper Sir Name __ Other_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA TELEPHONE AND EMAIL. _____initials**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH BE CONVEYED VIA TELEPHONE AND EMAIL. ----------initials**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products and services that 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 ____

Unable to communicate with patient ____

Patient refused to sign ____

Other (please describe) ____ _____

Signature of Privacy Officer