BIRKITT DENTAL

HIPAA Ominbus Rule

Patient Acknowledgement Form for Receipt of Notice of Privacy Practices Consent/Limited Authorization and Release Form

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

How do you want to be addressed when summoned from the reception area:

☐ First Name Only ☐ Proper Surname ☐ Other _____

Please list any other parties who are actively involved in your health care and who can have access to your health information (this includes step grandparents, grandparents and any care takers who can have access to the patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Email Confirmation
☐ Home Phone Confirmation ☐ Work Phone Confirmation ☐ Any of the Above

I authorize **information about my health** be conveyed via:

☐ Cell Phone ☐ Text Message to my Cell Phone ☐ Email
☐ Home Phone ☐ Work Phone ☐ Any of the Above

I approve being contacted about **special services, events, fundraising efforts or new health information** on behalf of Birkitt Dental via:

☐ Phone Message ☐ Text Message ☐ Email
☐ Any of the Above ☐ None of the Above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that Birkitt Dental may recommend products or services to promote your improved health. Our 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.

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 Patient Please **sign** Patient/Guardian of Patient

_____ _____
Legal Representative/Guardian Relationship of Legal Representative/Guardian

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement 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 Privacy Officer _____

18 Loudoun Street, SE • Leesburg, Virginia 20175 • p: 703-777-4440 f: 703-777-6254 w: birkittdental.com