LAS VEGAS ENDODONTICS

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, send reports to your dentist or release any information to other parties.

Click on the hyperlink to obtain a copy: *Notice of Privacy Practices*

Patient Name _____ Birth Date _____

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 CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any caretakers who can have access to your records):

Name _____ Relationship _____

Name _____ Relationship _____

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
❑ Work Phone Confirmation ❑ Email 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
❑ Work Phone Confirmation ❑ Email Confirmation ❑ Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

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

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 OR INSURANCE COMPANY IN THE FUTURE.

By signing this HIPAA Patient Acknowledgement Form, I acknowledge and authorize, that this office may recommend products or services to promote 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.

Signature of Patient, Parent or Guardian:		**Date:**	
IF PATIENT IS A MINOR			
Form signed by:		**Relationship to Patient:**	