northern colorado
orthodontics

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.

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 / facilities in the future.

_____ _____

Please *Print* Name of Patient Please *Sign* for Patient / Guardian of Patient

_____ _____

Guardian / Legal Representative Relationship of Guardian / Legal Representative

Your comments regarding Acknowledgements or Consents: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes stepparents, grandparents and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, and for TREATMENT and/or BILLING INFORMATION VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Email Confirmation (Preferred email: _____)
- ☐ Text Message to my Cell Phone (Preferred number: _____)
- ☐ Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Email Confirmation (Preferred email: _____)
- ☐ Text Message to my Cell Phone (Preferred number: _____)
- ☐ 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)

DO YOU HAVE A PREFERENCE IN HOW YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

- ☐ First Name Only
- ☐ Proper Surname
- ☐ Other: _____

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.

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
- ☐ 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: _____

Jill K. Mioduski, DDS, MS
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