HOLT FAMILY DENTISTRY

Sheila Gordon-Holt, D.D.S., P.A.

HIPPA OMNIBUS RULE

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 <u>We MAY NOT BE ALLOWED TO PROCESS YOUR INSURANCE CLAIMS.</u>

Please print your name:_____

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.

_____ (Initial here) Acknowledge that Holt Family Dentistry corresponds electronically and /or over the phone with referral doctors with health information.

Please list any other parties who can have access to your health information:
(This includes spouse, friend, care taker or family member ie; parent, step parent, child, or grandparent,)

Name:_____ Relationship:_____

Name:_____ Relationship_____

I authorize contact from this office to <u>Confirm my Appointment, Treatment,& Billing Information</u> VIA:

- ☐ Cell phone confirmation
- ☐ Home phone confirmation
- ☐ Work phone confirmation
- ☐ Email confirmation
- ☐ Any of the above

In signing this HIPPA 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 HIPPA Omnibus rule, provide you this information with your knowledge and consent.

You may revoke this authorization in writing or by updating this form.

_____ _____

Patient Signature Date

_____ _____

Legal representative Description of Authority