TURNAGAIN DENTAL

Acknowledgment of Receipt of Notice of Privacy Practices.

You may refuse to sign the acknowledgment & 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 the healthcare facility. A copy of this signed dated document that shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PATIENT HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient ***Signature*** of Patient/Guardian of Patient

_____ _____

Name of Legal Representative/Guardian Relationship to Patient

Your comments regarding Acknowledgment of Consent: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION:
(This includes step parents, 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, TREATMENTS, & BILLING INFORMATION and INFORMATION ABOUT MY HEALTH** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone

☐ Home Phone Confirmation ☐ Email Confirmation

☐ Work Phone 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:

☐ **YES** ☐ **NO** (opt out)

In signing this HIPPA Patient Acknowledgment form, you acknowledge and authorize that this office may recommend products and 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.

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