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 **Jennifer Kluth, DMD LLC**. 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** your name Please **sign** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents:_____

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 this patient's records)

Name:_____Relationship_____

Name:_____Relationship_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:**

__ Cell Phone Confirmation
__ Home Phone Confirmation
__ Work Phone Confirmation
__ Email Confirmation

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

__ Cell Phone Confirmation
__ Home Phone Confirmation
__ Work Phone Confirmation
__ Email Confirmation

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 an emergency treatment
__ I could not communicate with the patient
__ The patient refused to sign
__ The patient refused to sign because_____
__ Other (please describe)

_____

Signature of Privacy Officer