Prosthodontics Intermedica
467 Pennsylvania Avenue
Fort Washington, PA 19034
215-646-6334

HIPAA 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, you understand that Pi Dental Center *may not be permitted* to process your insurance claims or communicate with other critical parties related to your care.

Date: ______________________________

Patient Name: ______________________________ Chart Number: ________________

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.

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

☐ First name only ☐ Proper surname (Last Name) ☐ Other ________________________

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

Name: _________________________ Relationship: _____________________________

Name: _________________________ Relationship: _____________________________

Name: _________________________ Relationship: _____________________________

Name: _________________________ Relationship: _____________________________

Name: **All healthcare personnel involved in my treatment (past, present and future)** ***INITIAL HERE*** _______

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

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

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

☐ Cell Phone
☐ Home Phone
☐ Work Phone
☐ Text Message to my Cell Phone
☐ Email
☐ Voice mail on all phones
☐ **Any of the Above**

SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO

I understand that I am able to unsubscribe to any email newsletters myself but by unsubscribing, I may miss pertinent dental, medical or office policy information. ***INITIAL HERE:*** _____**See Side 2 →**

I hereby consent to the use, reuse, production and reproduction at any time by Prosthodontics Intermedica or their designees, my likeness or resemblance as presented in photographs of my oral and facial structures and their publication for public and teaching or professional educational and scientific purposes. In formats as follow:

On audio/video or other forms of recording	[ ] Yes	[ ] No
On the Internet	[ ] Yes	[ ] No
In printed format	[ ] Yes	[ ] No
Office photo album	[ ] Yes	[ ] No

May we use your clinical care and photograph to educate the public? [ ] Yes [ ] No

I understand that the nature of the dental practice can allow sound to travel between treatment areas. I am aware that it is my right to request that the door of my operatory be closed to maintain privacy if I desire.
INITIAL HERE ________

I understand that my dental records will be stored and transmitted in printed and electronic format.
INITIAL HERE ________

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.

Your comments regarding Acknowledgements or Consents:

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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	Signature of Patient / Legal Representative / Guardian
______________________________	______________________________
Name of Legal Representative / Guardian	Relationship of Legal Representative / Guardian to Patient

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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) _____

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Signature of Privacy Officer