BENNINGTON DENTAL CENTER

Family and Cosmetic Dentistry

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATAION & 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** Patient/Parent/Guardian of Patient

_____ _____

Please **print** name of Parent/Guardian Relationship of Legal Representation/Guardian

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 **care takers** who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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
[ ] Any of the Above

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

[ ] Cell Phone Confirmation
[ ] Home Phone Confirmation
[ ] Work Phone Confirmation
[ ] Email Confirmation
[ ] Any of the Above

In signing this HIPPA Patient Acknowledgement Form you may 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.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

It was emergent treatment ____
The patient refused to sign ____
Other ____
I could not communicate with the patient ____
The patient was unable to sign because ____
Signature of Privacy Officer _____