ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement but, in refusing we *will 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 Manning Orthodontics. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI(Personal Health Information) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

______________________________ ______________________________ ______________________________

Please ***print*** your name | Please print patients name (if under 18) | Please ***sign*** your name

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL AND/OR APPOINTMENT INFORMATION. **LEAVING THESE SPACES BLANK PROHIBITS US FROM GIVING INFORMATION TO GRANDPARENTS, SCHOOL NURSES, ATTENDENCES OFFICES, STEP-PARENTS, OR OTHER PARTIES WHO MAY ASSIST IN BRINGING YOUNGER PATIENTS TO THEIR APPOINTMENTS:**

NAME	**RELATIONSHIP**	Please check which information can be released to whom			
		Appointments (√)	Insurance (√)	Treatment (√)	Financial (√)

Please Initial ____ I AUTHORIZE THE RELEASE OF MY/ MY CHILD'S DENTAL INFORMATION TO THEIR GENERAL DENTIST AND OTHER DENTAL SPECIALISTS.

Please Initial ____ I AUTHORIZE THE RELEASE OF MY/ MY CHILD'S APPOINTMENT VERIFICATION TO THEIR SCHOOL/EMPLOYEER (for Healthcare Excuses).

Please Initial ____ I AUTHORIZE THE RELEASE OF MY CHILD'S DENTAL/PRESCRIPTION INFORMATION TO THEIR SCHOOL NURSE/CHILDCARE PROVIDER.

Please Initial ____ I AUTHORIZE THE RELEASE OF MY/MY CHILD'S APPOINTMENT AND DENTAL INFORMATION TO THEIR DENTAL INSURANCE COMPANY.

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS** VIA (√ all that apply):

- □ Email Confirmation (this is our primary system for appointment reminders, not checking this box will be opting out of regular appointment reminders)
- □ Home Phone Confirmation
- □ Work Phone Confirmation
- □ Text Message to my Cell Phone
- □ Cell Phone Call Confirmation
- □ U. S. Mail / Postcard
- □ **Any of the above**

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH, TREATMENT & BILLING INFORMATION** TO BE CONVEYED VIA (√ all that apply)::

- □ Message on Cell Phone
- □ Message on Home Phone
- □ Personal Conversation on Work Phone
- □ Personal Conversation on Home Phone
- □ Personal Conversation on Cell Phone
- □ Text Message
- □ Email Message
- □ U. S. Mail
- □ **Any of the above**

IS THERE ANYONE YOU SPECIFICALLY DO NOT WANT ANY MEDICAL INFORMATION RELEASED TO (PLEASE LIST):______________________________

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) _____

____
Signature of Privacy Officer

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ____ Date of Birth: ______________

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Kendra Covington Pratt, DDS, MS, PA; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

____

Signature of patient or parent/legal guardian/legally responsible person

____

Date

____

Description of relationship to patient

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions

Part 1. Complete if signature requested but not obtained:

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

- ○ Patient/personal representative refused to sign form
- ○ Other _____________________________________

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:

- ○ Form mailed/sent to patient/personal representative on (date): _____________

Part 3. Complete if either Part 1 or Part 2 completed:

___________________________________ ___________

Signature of staff member Date