St. Louis PEDIATRIC DENTISTRY
Evan Reed, DDS • Lindsey Reed, DDS
Amy LeCave, DDS • Jaime Orrick, DDS

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 we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

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, ACCOMPANIED BY WRITTEN CONSENT.

_____ _____

Please **print** your name (Responsible Party) Please **sign** your name (Responsible Party)

_____ _____

Legal Representative (If NOT Responsible Party) Description of Authority (If NOT Responsible Party)

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
First Name Only Proper Sir Name 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: _____

In signing this form, you acknowledge that all addresses, phone numbers, email address that you have provided us will be used for your contact from this office. Unless stated otherwise here:

_____

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFORMATION** on behalf of this Health Care Facility VIA:

Phone Message **None of the Above** (opt out)

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 was unable to because:

It was Emergency 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

St. Louis Pediatric Dentistry
O'Fallon T: 636-244-2620
Des Peres T: 314-394-1914
Chesterfield T: 636-778-2333
E: office@stlouiskids.net F: 636-244-3660