HIPAA OMNIBUS RULE

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

PARK AVENUE DENTAL ASSOCIATES, INC.

500 Park Avenue
Revere, Ma 02151
Tel: 781-284-1177 Fax: 781-286-1176

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

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 / FACILITYS 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 Sir 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: _____

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

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

Dear patient:

Your insurer will pay for necessary Covered Services for its Members as stated in your policy (Member Handbook). Each dental health plan has many products, which may provide different levels of insurance coverage for health care services. Please consult your policy or check with your dental health plan to confirm whether the services you will receive today are Covered Services, such as insurance copayments, deductibles and coinsurance. Certain plans do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. And it is also your responsibility to make sure our doctors are covered under your plan. With the many small insurance plans and self-insured plans coming up each day, it is impossible for our staff to know the rules and regulations of your individual plan .As doctors we treat patients, according to their needs, based upon current recommendations and guidelines. While we do our best to keep costs in mind, our primary responsibility is to provide the best and most appropriate care possible. If you have any questions, or concerns, please address them to the provider you is treating you.

Financial Responsibility: By singing below, you are accepting financial responsibility for all charges for services rendered to you. The parent or guardian accompanying the child assumes financial responsibility for today's charges, i.e., co-payments, deductibles, and non-covered services. It is our policy to charge a minimum of $60 for no show appointments and $50 for cancelled without a full business day advanced notice appointments. Please mark all your scheduled appointments on your personal calendar as reminder cards or calls are courtesy of this office and are not %100 guaranteed. If you are absent from treatment for 3 or more years, you will require a full new patient consultation. Every patient requires a full, comprehensive examination at least once every 5 years. This may vary depending on individual patient medical history.

Please print name: _____ Signature: _____Date: _____

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 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