nathan THOMAS orthodontics

HIPPA 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: _____

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** for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian | Relationship of Legal Representative/Guardian

Your comments requarding Acknowledgement or Consents: _____

_____

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: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to **confirm my appointments, treatment, billing information & new health information** via: Check all that apply.

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ Other _____

I consent to the use of my personal image and likeness, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, by **Nathan Thomas** for any lawful use **Nathan Thomas** deems appropriate, including for treatment and advertising of his services to the general public (including via social media and electronic media), illustration, and publication to the public at large for educational purposes.

I hereby relinquish any and all rights to my likeness or any image of me obtained by any photographic or digital means by **Nathan Thomas** during the course of my treatment. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

All reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand, however, that **Nathan Thomas** cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

_____ _____

Patient Name | Patient/Guardian Signature

_____ _____

If patient is a minor, guardian name & relationship to patient | Date

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We attempted to obtain written acknowledgement of reciept of our Notice of Privacy Practices, but acknowledgement could not be obtained because the individual refused to sign. Initialed 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.