Cosmetic & Family Dentistry

Debra Reiner & Associates

(734) 847-1955

8339 Lewis Ave. Temperance, MI 48182

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

Please List any other parties who can have access to your health information:

(This includes step parents, grandparents (etc.) and any care takers who can have access to the patients records)

Name:______________________________ Relationship:__________________Tel (___) _____ - _______

Name:______________________________ Relationship:__________________Tel (___) _____ - _______

☐ Myself only, no other family members (please be aware that by checking this we will not be able to discuss appointment information with anyone but the patient.)

How our office will communicate with you in regards to your Oral Health

For your convenience our office uses an automated system to confirm appointments. I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, BILLING, AND (if sent to) COLLECTION. **INFORMATION MAY BE SENT VIA**: Cell, home, work, text, email and by mail.

Initial:_______ Primary phone # to be contacted at: (___) _____ - _________

In signing this HIPPA 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 HIPPA Rule, provide you this information with your knowledge and consent.
I understand that I have access to or have reviewed Cosmetic and Family Dentistry *Notice of Privacy Practices* for the following medical practice:

8339 Lewis Ave. Temperance, MI 48182
Tel: (734) 847-1955
Privacy Official: Jona Hoffman-Office Manager

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

_________________________________ _________________________________
Legal Representative/Guardian Relationship of legal Representative/Guardian

Date: ______________