

Cosmetic & Family Dentistry



Recca Puri, DDS

(734) 847-1955

8339 Lewis Ave. Temperance MI 48182

Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent/Limited Authorization & Release

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

Date: _____ Patient Name: _____

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 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 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 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

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