Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Patient name: _____ Birthdate: ___/___/____

I have received either a paper or an electronic copy of the HIPAA Notice of Privacy Practices for Inspirational Smiles. I understand that I am entitled to receive a paper copy of the Notice if I ask for it, even if I have already agreed to receive only an electronic copy.

X _____ Date signed:_____
Signature of patient, guardian, or personal representative

If applicable:
Patient's Guardian or Representative's name: _____ Phone: _____

Representative's relationship to patient: _____

Representative's address: _____

Permission To Discuss Treatment Or Billing Information

I give my permission to discuss my treatment and or billing information with:_____ Relationship to patient: _____

APPOINTMENT REMINDERS

We will remind you of upcoming appointments by using text and e-mail messages. Please make sure that we have your current cell phone numbers or email addresses for your reminders.

Cell phone number _____

Email address _____

For office use only:

Please complete the following only if the acknowledgment section above has not been signed by the patient or the patient's personal representative; We made a good faith effort to obtain a written Acknowledgment of Receipt of Notice of Privacy Practices, but an acknowledgment could not be obtained because *(please check one or more as appropriate)*:

___ The patient or the patient's personal representative refused to sign.

___ A communication barrier prevented us from obtaining an acknowledgment.

___ An emergency situation prevented us from obtaining an acknowledgment.

___ Other (please explain) _____

Completed by: _____ Position: _____

Staff member's initials: _____ Date completed: _____

202 Tribble Gap Road, Ste 101, Cumming, GA 30040
Tel: (678)341-9101 Fax: (678)771-8925