MORE T CLINICS

HIPAA 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.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this Healthcare Facility (More T Clinic Site 1, LLC operating under the service mark More T Clinics). A copy of this signed, dated document (e.g., by email or fax) 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 / FACILITY IN THE FUTURE.

Date: _____

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative (if applicable) Description of Authority for Legal Rep.

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 spouse, children, step parents, grandparents, and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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1. I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED AND CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT, AND BILLING INFORMATION** VIA:

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

2. I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED **TO MY INSURANCE PROVIDER(S)**:

☐ YES (any) ☐ NO (In refusing we *will not be allowed* to process your insurance claims on your behalf.)
☐ YES, but only the following provider(s): _____

3. I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS, OR NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health, and this office may receive third party remuneration from affiliated companies of such products/services. 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 _____ Signature of Privacy Officer
The patient was unable to sign because _____
Other (please describe) _____
_____