Midwest Orthodontic Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I hereby acknowledge that I have had an opportunity to review and/or am able to request a copy of this office's Notice of Privacy Practices.

Patient Name

Patient or Guardian Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify)

_____

_____

Patient Name: _____

Midwest Orthodontic Associates is authorized to release protected health information about the above-named patient to the parties named below. **(Note: If the patient is a minor, information will be given to both parents unless deemed inappropriate pursuant to state law or court order.)**

_____ _____

Signature of Patient or Responsible Party Date

Description of information to be released

Treatment information and recommendations

Results of tests / x-rays

Appointment reminders and history

Financial information: description of service, fee, payment plan, balance

Insurance information including description of service, fee, benefits paid, balance

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
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Name	Relationship	Phone Number
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