HIPAA OMNIBUS RULE

Pentatonic Therapies, LLC

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.

Date: _____

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 BE SENT TO OTHER THERAPIST / FACILITIES IN THE FUTURE.

_____ _____

Please print name of Patient | Please sign for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian | Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes stepparents, grandparents and any care takers who can have access through written or verbal communication to this patient's records):

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Other Therapists_____
School Name: _____
Please list any other/s _____
Please indicate any custody, divorce or family matters we should be aware of_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

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

I AUTHORIZE INFORMATION ABOUT MY SERVICES BE CONVEYED VIA:

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

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent. By signing below, you acknowledge understanding and acceptance of the Pentatonic Therapies, LLC HIPAA Private Practice Notice.

_____

Parent/Legal Guardian Signature Date Printed Name