Reset Form

SPECTRUM Services
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www.SpectrumSocial.net • Info@SpectrumSocial.net
Phone (512) 524-5482 • Fax (512) 524-1177

CLIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

Client Name: _____ Date Completed: _____

Name of Person Completing Form (if different from applicant): _____

Relationship to Applicant: _____

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process insurance reimbursement paperwork or requests for information.

The undersigned acknowledges opportunity to review and/or receive a copy of the currently effective Notice of Privacy Practices for this facility. A copy is available in the office, on our website and by email to the client upon request. A copy of this signed, dated document shall be as effective as the original.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

☐ Phone Confirmation ☐ Text Message ☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY SERVICES** BE CONVEYED VIA:

☐ Phone Confirmation ☐ Text Message ☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES and EVENTS** being held by Spectrum:

☐ Phone Confirmation ☐ Text Message ☐ Email Confirmation
☐ **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. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

_____ _____
Signature of Adult Client / Parent / Legal Guardian Date

_____
Printed Name of Adult Client / Parent / Legal 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 ____
Other (please describe) ____

_____
Signature of Privacy Officer