HIPPA OMINIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM FOR LUIS C OMPHROY MD LLC

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claim

Date: _____

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

Name	Relationship	Name	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE CIRCLE YOUR PREFERRED METHOD OF COMMUNICATION:

Home Phone ☐ **Cell Phone** ☐ **Text message** ☐ **Email: _____**

Can we leave automated appointment reminders on your home or cell phone? ☐ **YES or NO** ☐

NO SHOW/NO CALL POLICY

The office of Dr. Luis C. Omphroy will make every effort to see you at your scheduled time. We believe it is important that we stay on time. We also believe that regular follow-ups and continuity of care is important to your health maintenance.

We would appreciate the same courtesy:

- We will give you a courtesy call and/or text message to remind you of your appointment
- Kindly give our office at least a 24-hour notice if you are unable to keep the appointment as scheduled and we will gladly reschedule it
- **There will be a $50.00 fee for all No shows or No call appointments, you may call the day of your appointment to cancel to avoid the $50 fee, if it is prior to the scheduled time.**
- If you are running late, please call the office to see if we are still able to see you. We may need to reschedule your appointment. **(YOU DO HAVE A 15-MINUTE GRACE PERIOD)**

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this health care facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS
A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

PLEASE PRINT AND SIGN BELOW TO ACKNOWLEDGE THE ABOVE STATED POLICY:

_____ _____
PLEASE PRINT NAME **DATE**

_____
SIGNATURE