

MIDWEST ORAL AND MAXILLOFACIAL SURGERY, P.C.

WRITTEN ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES
(Effective September 23, 2009)

The undersigned hereby acknowledges and certifies that he/she will be offered a copy of Midwest Oral and Maxillofacial Surgery, P.C.'s ("MOMS") Notice of Privacy Practices, at the time of their appointment.

Date: _____

Signature of Individual: _____

If individual is unable to make written acknowledgement because of age or physical condition, complete the following:
Individual is: a minor, _____ years of age; or (state the reason) _____

State relationship to patient: _____

Signature of Representative/Legal Guardian: _____

Printed Name of Representative/Legal Guardian: _____

Date: _____ Name: _____

Patient's Date of Birth: _____ Patient's Phone #: _____

I here by authorize the staff of Midwest Oral and Maxillofacial Surgery to discuss any necessary medical and billing information on my behalf with:

Table with 4 columns: Name, D.O.B., Relationship, Phone #

The above person/persons will have authority to call on my behalf until I revoke this in writing.

Signature: _____

There will be no one calling on my behalf regarding my medical or billing information. Do not share information regarding me with anyone other than authorized medical personnel.

Signature: _____

NOTICE OF FINANCIAL INTEREST IN HEALTHCARE ENTITY

In the course of your diagnosis and treatment, the physicians may refer you to other providers and facilities for services. Hospitals in the area provide inpatient and outpatient services upon referral from our doctors. One or more of the physicians of Midwest Oral and Maxillofacial Surgery, P.C. is part owner of, and has a financial interest in Dupont Hospital, LLC, Lutheran Hospital, St. Joseph Hospital and Rehabilitation Hospital of Fort Wayne.

We want to make sure you are aware of our financial interest in Dupont Hospital, LLC, Lutheran Hospital, St. Joseph Hospital and Rehabilitation of Fort Wayne. It may be necessary for us to refer you there for services from time-to-time. However, the selection of a specific health care entity/facility always rests with you, the patient, and you may choose at any time to be referred to an alternate entity/facility of your choice.

By signing below you acknowledge and certify that you, the patient or patient representative, have received a copy of this Notice of Financial Interest in Healthcare Entity.

Signature of Individual: _____

Printed Name of Individual: _____

Date: _____

If the individual is unable to make written acknowledgement because of age or physical condition, complete the following:

Individual is a minor, _____ years of age; or (state the reason) _____

Relationship to patient: _____

Signature of Representative/Legal Guardian: _____

Printed Name of Representative/Legal Guardian: _____

Date: _____