Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement discussed above) us to first obtain your written consent prior to disclosing any of your information except for you disclosure in connection with : a defense to a claim challenging our professional competence; a review entity's function; a claim for payment of fess/ a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time t may be necessary for us to make a disclosure of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature *Patient Name (please print)*

I am also signing for my minor children: _____

Please Print Names

Date:_____

For Office Use Only

Patient refused to sign.
The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient from signing the Acknowledgement.

_____ _____

Office Personnel Signature *Office Personnel Printed Name*

*Date:*_____

Patient Consent

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, caregiver)

_____

_____

Please Print Names

*Patient Signature:*_____ *Patient Name (Printed):*_____

Date: _____