

## Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability And 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 acknowledgment, discussed above) us to first obtain written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order a part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make a disclosure of your information in connection with your 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

*Please sign this form below under the heading "acknowledgement" to acknowledge that you have today read and given the opportunity to receive a copy of our notice of privacy practices.*

I acknowledge that I have today received a copy of the Notice of Privacy Practices to read and my have my own personal copy to take with me if so requested.

X \_\_\_\_\_  
Signature of Patient or Legal Guardian Printed Name

Date \_\_\_\_\_ Relationship to Patient if a Minor \_\_\_\_\_

### PATIENT CONSENT

*Please sign this form below under the heading "Consent" to consent to our disclosure of your information that we deem necessary in order to provide you with proper treatment.*

I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

X \_\_\_\_\_  
Signature of Patient or Legal Guardian Printed Name

Date \_\_\_\_\_ Relationship to Patient if a Minor \_\_\_\_\_

If you are over the age of 18, please be advised that we may discuss your treatment, financial arrangements and benefits with parents or guardians living at your same address. Advise us in writing if there are to be any exclusions.

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 (print name)

\_\_\_\_\_  
Date