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## Patient Acknowledgement and Consent Form

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

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or 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 below under the heading "acknowledgement" to acknowledge that you have today received a copy of our Notice of Privacy Practices.*

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

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (please print)

Date: \_\_\_\_\_

### Patient Consent

*Please sign this form below under the heading "Consent" to consent to our disclosures 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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (please print)

Date: \_\_\_\_\_

**For office use only**

Patient refusal to sign

The following circumstances prohibited the patient from signing the Acknowledgement:

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An emergency situation prevented the patient from signing the Acknowledgement.

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Office Personnel (signature)

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Office Personnel (print name)

Date: \_\_\_\_\_