Patient Acknowledgment and Consent Form

Effective April 14th 2003, the new federal law known as Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance if 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 own 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 your written consent prior to disclosing any of your information except for our disclosure in connection with: a defense to a claim challenging our professional competence; a review entity's function; a claim for payment of fees; 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 it may be necessary for us to make disclosure 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 disclosure of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgment" 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.

X_____
Name (please print)

X_____
Signature

X_____
Date

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

X_____ X_____
Patient Name (Please Print) Patient Signature

For Office use only

We attempted to obtain written acknowledgement of the recipient of our Notice of Privacy Practices, but could not because:

( ) Individual Refused to Sign
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Communication situation preventing us from obtaining acknowledgement
( ) Other (Please Specify) _____

_____ _____ _____
Office personal (Print name) Office personal signature Date