Patient Acknowledgement and Consent Form

****You May Refuse To Sign This Form****

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 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 HIPPA's requirements, we are giving you a copy of our **NOTICE OF PRIVACY PRACTICES**. This Notice of Privacy Practices contains the information that HIPPA requires us to disclose regarding our privacy practices. Existing Michigan Law requires us (in addition to our attempt to obtain your written acknowledgment as discussed above) to first obtain your 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 of this entity's functions; 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 disclosures 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 information to a dental laboratory or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement & Consent

I, ________________________________, have received a copy of this office's Notice of Privacy Practices. I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature: ____**Date**: ___________________________

Patient/and or Guarantor Signature: ____

Relationship to Patient (if other than patient) ________________________________

The following individual (s) may also have access to my records and health information

Name: _____________________________ **Relationship to Patient:** _____________________________________

****FOR OFFICE USE ONLY****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__ Other (Please Specify) ____