

Family Dentistry of Caledonia

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 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 entity's functions; a claim for payment of fees; a third party payers examination of our records; a court order as part of a criminal investigation, an identification of a dead body; a licensing 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 a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordination your treatment

Patient Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

Please sign this form under the following statement 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 (GUARDIAN IF UNDER 18 YEARS)

Patient Name (PLEASE PRINT)

Date: _____

For Office Use Only

PATIENT REFUSED TO SIGN

The following circumstances prohibited the patient from signing the Acknowledgment:

 An emergency situation prevent the patient from signing the Acknowledgement

Office Personnel (signature)

Office personal (print name)

Date: _____

Patient Consent

Please sign this form under the following statement to consent to our disclosures 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 such disclosures may not be of the type listed above.

Patient Signature (GUARDIAN IF UNDER 18 YEARS)

Patient Name (PLEASE PRINT)

Date: _____

Staff initials _____