PATIENT ACKOWLEDGEMENT

Effective April 14, 2003, the new federal law know 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 giving you a copy of our Notice of Privacy Procedures. This notice contains the information that HIPPA 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 obtain your written consent prior to disclosing any of your information except for 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 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 professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Please sign this form below to acknowledge that you have today received a copy of our Notice of Privacy Practices.

_____

Signature *Date* *Print Name*

_____

For office use only

The 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 *Date* *print name*

PATIENT CONSENT

I consent to your disclosure of information regarding my dependants and/or myself, which you deem are necessary in connection with treatment. I understand that such disclosures may not be of the type listed above.

Please print the FIRST AND LAST names of all dependants in your family under the age of 18.

_____

_____

_____

Signature of Patient, Parent/Legal Guardian *Date* *Name (Please Print)*