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## Notice of Privacy Practices Patient Acknowledgement

Effective April 14, 2003, the 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 health 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 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'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 health information in connection with your treatment.

**For example:** We may make a referral 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.

**Please circle: YES or NO that you have read and understand our practice Notice of Privacy Practices.**

### Consent for Services:

I consent to dental treatment for myself or my dependent(s) as agreed on at the time of treatment. As a condition of treatment, any dental services performed must be paid at the time of service. Patients with dental insurance understand they are responsible for their account. Our office will prepare the insurance forms and bill the insurance company. We will credit any insurance payments to the patients account. However, we cannot render services on the assumptions that our charges will be paid by insurance. Insurance companies can and do deny payments for a variety of reasons.

*I have read the above conditions of treatment and payment and agree to their content:*

Print Name: \_\_\_\_\_

Patient Signature (if 18 or older): \_\_\_\_\_

Guardian/Parent's Signature: \_\_\_\_\_

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