Patient Acknowledgement and Consent Form

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 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 Practice contains the information that HIPAA requires us to disclose regarding our privacy practices.
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 coordinating your treatment.

Patient Acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature Patient Name (please print)

Patient Consent

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 Patient Name (please print)

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver)

_____

_____

Patient Communication Preferences

May we leave a message on Cell, Home, or Work: Yes _____ No _____

Date: _____

For office use only

Patient refused to sign.
The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

_____ _____

Office Personnel (Signature) Office Personnel (print name)