Healthy Smile Center

9 N WASHINGTON, OXFORD, MI 48371 PH. 248-969-4840

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 given 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 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.

PATIENT ACKNOWLEDGMENT

Please sign this form below under the heading "acknowledgement" 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	**Patient Name (please print)**	**Date**

For Office Use Only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment.
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An emergency situation prevented the patient from signing the Acknowledgement:

______________________	______________________	______________
Office Personnel Signature	Office Personnel (print name)	Date

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Family Members: With your approval and using our professional judgment, your health information may be disclosed to family members who are directly involved in your care. If you are unavailable, incapacitated, or in an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited health information with such individuals without your approval
Appointment Reminders and Test Results: Healthy Smile Center may contact you to provide appointment reminders, test results, or to give you information about treatments or health-related services that may be of interest to you. This may include voice mail messages, postcards, letters, e-mail and other forms of communication.

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

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)**	**Date**