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 offering 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 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 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

Please sign this form below under the heading "acknowledgement" to acknowledge that you may have a copy of our notices of privacy practices.

I acknowledge that a copy of the Notice of Privacy Practices is available to me.

Patient or Parent / Guardian Signature	Patient Name (please print)	Date

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 and the use of your name and photograph.

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

I authorize Family Dentistry of Lowell representatives to confirm dental appointments and mail information pertaining to dental appointments.

Patient or Parent / Guardian Signature	Patient Name (please print)	Date

Information such as appointments, treatment plans, cost, recommendations, etc. may be released to the following people:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

For office use only.

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	Office Personnel Print Name	Date