Mansfield Family Dentistry

Patient Acknowledgement and Consent Form

Effective April 14, 2013, 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 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 us (in addition to our attempt to obtain your written acknowledgement, discussed above) 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 collection agency; 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.

It may be necessary for us to make disclosures of your information in connection with your treatment. We may make a referral to, or consult with, another dentist or health care professional. We may need to email or fax any relevant healthcare information, including your x-rays, to another dentist, laboratory, or an insurance company. It may be necessary to 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 have been offered a copy of our Notice of Privacy Practices.

I acknowledge that I have today been offered a copy of the Notice of Privacy Practices:

X _____ X _____

Patient signature/Legal Guardian | Patient name (please print)

X _____

Date

I authorize permission for _____ to discuss my account, treatment, or insurance information with Mansfield Family Dentistry.

The above person's relationship to me is: _____

For Office Use Only

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

_____

Office Personnel Signature: _____ Office Personnel Print: _____