



Patient Acknowledgment 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 the HIPAA 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. 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 Acknowledgment

Please sign this form below under the heading to acknowledge that you have received a copy of our notice of privacy practices.

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

I give permission for postcards to be mailed for patient communication

Patient or Parent/Guardian Signature

Patient Name (Please Print)

Date

For Office use only

Patient Refused to Sign

The following circumstances prevented patient from signing the Acknowledgment

An emergency situation prevented the patient from signing the Acknowledgment

Office Personnel Signature & printed name

Date