

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement and Consent

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 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 our treatment. For examples, 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.

Acknowledgement of Receipt

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

Patient Signature (parent if minor)

Patient Name (pls. print)

Date: _____

Reg'd

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 (parent if minor)

Patient Name (pls. print)

Date: _____

Reg'd

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)

Date: _____