BLOOMFIELD HILLS dental associates

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 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 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 Acknowledgement

Please sign this form below to acknowledge that you have today either received or reviewed 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)

I am also signing for my minor children: _____
(please print names)
Date: _____

Patient Consent

Please sign this form below 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)

I am also signing for my minor children: _____
I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver)

_____
(please print names)

_____

_____

I also give my permission for information regarding ____ treatment ____ appointments, ___ insurance benefits, ___ financial arrangements to be discussed with the above individuals. Date: _____

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: _____

36700 Woodward Avenue . Bloomfield Hills, MI 48304 . Suite 200
ph: 248 290 2290 | fax: 248 290 2904 | info@bloomfieldhillsdental.com
www.bloomfieldhillsdental.com