Caring Family Dentistry, P.C.
Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law on Health Insurance Portability and Accountancy Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of patient information we have collected and will collect in the future. To comply with one of HIPAA's requirement, we are giving you a copy of our Notice of Privacy Practices for reading and review. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practice.

Existing Michigan law requires us (in addition to our request to obtain your written acknowledgement) to obtain your written consent prior to disclosing any of your patient 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 examination of our records; a court order as a part of criminal investigation; a forensic identification; 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 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

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

______________________	______________________	______________
Patient's signature	Patient's printed name	Date
Parent's / legal guardian's signature	Parent's / legal guardian's printed name	Date

Patient Consent

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

______________________	______________________	______________
Patient's signature	Patient's printed name	Date
Parent's /legal guardian's signature	Parent's /legal guardian printed name	Date

I give consent for my health information to be given to:

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For Office use only: Patient's name ______________________________ Date ______________________

Patient refused to sign: ____ the Patient Acknowledgment ______ the Patient Consent

________ An emergency situation prevented the patient from signing the Acknowledgement.

The following circumstance prohibited the patient from signing the acknowledgement:

______________________	______________________	______________
Office personnel signature	Office personnel printed name	Date