Patient Name:_____

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, **Kids Smiles... Pediatric Dentistry** is giving you a copy of **of Privacy Practices.** This **Notice of Privacy Practices** contains the information that HIPAA requires us to **Notice** disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us 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 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.

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/your child's treatment.

Patient Acknowledgement

*Please sign below to acknowledge that you have received a copy of our **Notice of Privacy Practices.***

I the undersigned, **acknowledge** that I have received a **copy** of the **Notice of Privacy Practices.**

_____ _____

Patient/Parent/Legal Guardian Signature **Patient/Parent/Legal Guardian (Please Print)** **Date**

For Office Use Only
Patient Refused To Sign

The following circumstances prohibited the patient from signing this Acknowledgment:_____.

_____

_____ _____

Office Personnel(Signature) **Office Personnel (Print Name)** **Date**

Patient Consent

Please sign below to consent to our disclosures of your information that we deem necessary in order to provide proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my/my child's treatment. I understand that such disclosures may not be of the type listed above.

_____ _____

Patient/Parent/Legal Guardian Signature **Patient/Parent/Legal Guardian (Please Print)** **Date**