

# Belding Family Dentistry



Shawn Kinser, DDS

## Patient Acknowledgment and Consent (HIPPA)

Effective April 14, 2003, the new law known as the Health Insurance Portability and Accountability Act of 1996 ('HIPPA') 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 HIPPA's requirements, we are giving you a copy of our Notice of Privacy Practices for review. This Notice of Privacy Practices contains the Information that HIPPA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, discussed above), us to first obtain your written consent prior to disclosing any of your information except for your 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 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 'Acknowledgment' to acknowledge that you have reviewed a copy of our Notice of Privacy Practices.

**I acknowledge that I have received/reviewed a copy of the Notice of Privacy Practices.**

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Patient Name (please print)

### Patient Consent

Please sign this form below under the heading 'Consent' 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 in connection with my treatment. I understand that such disclosures may not be of the type listed above.**

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

### For Office Use Only:

Patient Refused to Sign. The following circumstances prohibited the patient from signing the Acknowledgment:

\_\_\_\_\_  
Office Personnel Signature

\_\_\_\_\_  
Office Personnel (please print)

\_\_\_\_\_  
Date