

Okemos Pediatric Dentistry, P.C.

517-381-5244

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal 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 child's 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. 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 child's 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 child's information in connection with their 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 child's information in connection with providing or coordinating your child's treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledge" that you have today received a copy of our notice of privacy practices.

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

X

Parent Signature Name of minor child 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 from signing the Acknowledgement.

Office Personnel (signature) Office Personnel (print name) Date

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your child's information that we deem necessary in order to provide your child with proper treatment. I consent to your disclosures of my child's information, which you deem necessary in connection with his / her treatment.

X

Parent signature Name of minor child Date