Patient Acknowledgement and Consent Form
NORTH OAKLAND DENTAL GROUP

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 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 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 obtain our 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 treatment.

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice, and treatment to a laboratory.

I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of the services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information filled out on the Registration, Dental and Medical History Forms.

I consent to your disclosures of my information, which you deem necessary in connection with my care, treatment, and coordination of benefit payments.

Patient's or Guardian's Signature: _____ Date: _____