MONICA LEWIS D.D.S., P.C.
KIM BRADFORD D.D.S., P.C.

Patient Acknowledgement and Consent Form

Effective April 14th 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, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA 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 our disclosures in connection with: a defense to a claim challenging our professional competence; a review of 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 consult with another dentist or other health 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

Please sign this form *to acknowledge that today you received a copy of our notice of privacy practices.*
I acknowledge that today I received a copy of the Notice of Privacy Practices.

Patient Signature	Patient Name (please print)	Date

Patient Consent

Please sign below to consent to our disclosures of your information that we deem necessary in order to provide you with the proper treatment. Also, provide the name(s) to whom we can share your medical information (ex. Family members, guardian, etc.)

Name(s) of whom we can share your medical information with.

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

Patient Signature	Patient Name (please print)	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 (please print)	Date