

## ALPHA OMEGA DENTAL CENTER, PLLC

Effective April 14, 2003, the new federal laws 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: 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.

### Patient Acknowledgement

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

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

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date

### 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 the proper treatment. You also acknowledge that Alpha Omega Dental Center, and Dr. Cynthia Wiggins, are not participating providers with any insurance company, and regardless of what the insurance company states on their EOB's, you are responsible for the full balance. Claims will be submitted as a courtesy, with request to send payment here, but any difference in the estimated co-pay is still the guarantor's responsibility.**

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above. I understand that I am responsible for any outstanding balance after insurance has paid.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date

### OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
Printed Personnel Name

\_\_\_\_\_  
Date

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