Patient Acknowledgement and Consent Form

The 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 the HIPAA's requirement, we are giving you a copy of our Notice of Privacy Practices. This notice of Privacy practices contain 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 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 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 to acknowledge that you 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	*Patient Name (please print)*	*Date*

For Office Use

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*

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with the proper treatment.

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. ________________

Initials

I agree that Dr. Tenaglia's Dental Practice may communicate with me electronically through email and/or text message. **I am aware that there is some level of risk that third parties might be able to read unencrypted emails/text messages.** I am responsible for providing the dental practice with any updates and I can withdraw my consent to electronic communications by calling: **517-347-6733**

____	____
Email Address	*Phone Number*

____	____	_____________________
Patient Signature or Parent (If Child)	*Patient Name (please print)*	*Date*