SIMONE FAMILY DENTAL

Patient Acknowledgement and Consent Form

Nick P. Simone, DDS, PLLC

Effective April 14, 2003, the 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 the HIPPA's requirements, we are giving you an opportunity to review our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPPA requires us to disclose regarding our privacy practices. If you would like to review the complete Notice of Privacy Practices in its entirety, please notify the receptionist.

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 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.

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

Patient or Guardian Signature	Patient Name (Please Print)	Date

I consent to your disclosure 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 or Guardian Signature	Patient Name (Please Print)	Date