

Patient Acknowledgment and Consent Form

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 will make available to you a copy of our Notice of Privacy Practices. This notice of Privacy Practices contains the information that 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 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 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 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 Acknowledgment

Please sign this form below under the heading "acknowledgment" to acknowledge that a copy of our Notice of Privacy Practices was made available to you.

I acknowledge that a copy of the Notice of Privacy Practices was made available to me.

Patient or Patient Representative Signature & Date

Patient Name (please print)

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 (Print Name)

Patient Consent

Please sign this form under the heading "Consent" to consent to our disclosures of your information that we may deem necessary in order to provide you with 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 be of the type listed above, and those listed in our Notice of Privacy Practices.

Patient or Patient Representative Signature & Date

Patient Name (please print)

Patient Record of Disclosures

Relative, friend or caregiver to whom pertinent information may be disclosed.

Name	Relationship	Home Telephone	Work Telephone	Duration

Comments: _____

Patient/Guardian Signature: _____

Date: _____