DENTAL SOUTH
PETER A. GARCHOW, DDS
630 36TH STREET, SW, GRAND RAPIDS, MI 49509

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FORM

Notice of Privacy Practices: Effective 4/14/03, the new federal law, Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected in the past 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 contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing MI Law requires us to attempt to obtain your signature acknowledging you have received the Notice discussed above.
- Existing MI Law also requires us to obtain your written consent prior to disclosing any of your information.

Purpose of Consent: From time to time it may be necessary for us to make disclosures of your information in connection with your treatment or payment. For example, we may make a referral to or consult with another dentist or other healthcare professional, use a dental laboratory, communicate with insurer or otherwise make disclosures of your information to provide or coordinate your treatment as outlined in our Notice of Privacy Practices.

You may refuse to sign this acknowledgement

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Dental South's Notice of Privacy Practices.

_______________________________ _____________________________________ _______________
Patient name (please print) *Signature (Parent or Guardian, if patient is a minor)* *Date*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies, but acknowledgement could not be obtained for the following reason(s):

☐ Individual refused to sign ☐ Communications barriers ☐ An emergency situation ☐ Other

(Please explain. Sign & Date)____

PATIENT CONSENT

I have had full opportunity to read the contents of this Consent form and I consent to your use and disclosure of my protected health information, which you deem necessary in connection with my treatment, insurance and payment activities and healthcare operations.

_______________________________ _____________________________________ _______________
Patient name (please print) *Signature (Parent or Guardian, if patient is a minor)* *Date*

I consent to have my case discussed with the following person(s):

Name: ______________________________________ Relationship to patient: ____________________________

Name: ______________________________________ Relationship to patient: ____________________________

If this is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name____

Relationship to Patient____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand this will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

A current Notice of Privacy Practices will always be posted in our office and a copy can be obtained at anytime by contacting our office. **YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER SIGNING**.

Include completed Consent in the patient's chart.