James D. Thomas, DDS, PC ♦ Kala Foster, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

Effective April 14, 2003, the new 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 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.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "PATIENT ACKNOWLEDGMENT" TO ACKNOWLEDGE THAT YOU HAVE TODAY RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with:

1. A defense to a claim challenging our professional competence;

2. A review entity's functions;

3. A claim for payment of fees;

4. A third party payer's examination of our records;

5. A court order as part of a criminal investigation;

6. An identification of a dead body;

7. A licensure investigation; or

8. 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.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "PATIENT CONSENT" TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have today received the Notice of Privacy Practices from this practice. I understand that routine protocol in the office includes the use of a sign-in sheet upon arrival, confirmation messages may be left on answering machines, voice mail, or with another individual answering the telephone regarding appointments if the patient is not available. I understand that postcards may be used to remind patients of future appointments or need for them. The office may remind patients to take medications prior to the appointment when leaving messages. The office may also use electronic mail (e-mail) to communicate with patients.

{Patient Signature}

{Please Print Name}

{Date}

For Office Use Only

☐ Patient refused to sign

☐ The following circumstances prohibited the patient from signing the Acknowledgement:

_____

_____

☐ An emergency situation prevented us from obtaining acknowledgement.

_____
{Office Personnel Signature}

_____
{Office Personnel Print Name}

_____
{Date}

PATIENT CONSENT

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.

{Patient Signature}

{Please Print Name}

{Date}

A copy of this signed form (including electronic storage and retrieval) will be considered the same as the original.