

HEALTHY POINTE DENTAL, PC  
**Patient Acknowledgement 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.

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 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 under the heading "acknowledgement" to acknowledge that you have today 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 (Parent/Guardian) Signature

\_\_\_\_\_  
Patient Name (please print) Date

\_\_\_\_\_  
Children's Name (under 18 years of age)

**For office use only**

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment:

\_\_\_\_\_  
An emergency situation prevented the patient from signing the Acknowledgment.

\_\_\_\_\_  
Office Personnel (signature)

\_\_\_\_\_  
Office Personnel (print name)

\_\_\_\_\_  
Date:

**Patient Consent**

*Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we 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 not be of the type listed above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

**HEALTHY POINTE DENTAL, PC**

18100 Mack Avenue  
Grosse Pointe, MI 48230

**Consent to Release Information**

I, \_\_\_\_\_, authorize Dr. Allison Elston, Dr. James Everett, or a member of their staff to share billing, financial information, dental and medical history, conditions, findings, radiographs, recommended treatment, and any other pertinent information as it relates to my dental treatment with the following individual(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

May we leave messages on your answering machine/voicemail? Yes \_\_\_\_\_ No \_\_\_\_\_

HIPAA requires permission to leave messages on an answering machine/voicemail (45 CFP 164.502[a][1][i]).

Please list an emergency contact who is authorized to receive any pertinent information regarding your dental health as requested by Dr. Allison Elston, Dr. James Everett or authorized staff member.

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Printed)