ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

Family Dental Clinic 1119 Sims Dickinson ND 58601

I have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

If you are signing this Consent on behalf of a patient, please complete the following:

Relationship to patient: _____

Name of patient: _____

I ALLOW FAMILY DENTAL CLINIC TO RELEASE INFORMATION CONCERNING MY DENTAL, HEALTH AND ACCOUNT INFORMATION TO THE FOLLOWING PARTIES:

(Please include spouse, children, step parents, grandparents, care taker, and any other person you would like to have access to this patients records.)

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Individual refused to sign

____Communications barriers prohibited obtaining the acknowledgment

____An emergency situation prevented us from obtaining acknowledgment

____Other (please specify) _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my (or my child's) records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my (or my child's) records to all persons who are involved in my care, (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

PATIENT'S OR GUARDIAN'S SIGNATURE

_____ DATE _____