AMICUS Dental Centers

# Amicus Dental Centers 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 the HIPAA's requirements, we are making available to you a copy of our Notice of Privacy Practices (copy available in our office). This notice contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Florida 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/Consent

*Please sign this form below to acknowledge that a copy of our notice of privacy practices has been made available to you and to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.*

I acknowledge that a copy of the Notice of Privacy Practices has been made available to me (Copy available in our office). I also consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

| Patient Signature (Parent sign, if minor) | Date | Patient Name (Please Print) |
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## 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) | Date | Office Personnel (Print Name) |
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