**RONALD F. KONOPKA, D.D.S.**
**PATIENT ACKNOWLEDGMENT 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 collect in the future.

To comply with one 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 "ACKNOWLEDGEMENT" TO ACKOWLEDGE 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 "CONSENT" TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.**

**PATIENT ACKNOWLEDGMENT**

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____
Patient Signature Date Patient Name (print name)

**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 Date Patient Name (print name)

Permission is given to disclose information to _____

_____

**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) Date Office Personnel (print name)