ZOMA DENTAL

FAMILY AND COSMETIC DENTISTRY

Patient Communication Consent (HIPAA)

Effective April 14th, 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, you are entitled to read a copy of our Notice or Privacy Practices. Existing Michigan law requires us to 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 an 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 specialist or health care provider or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

By law, without your authorization, Zoma Dental cannot communicate with: Your spouse, your adult children, your caregivers, your parents (if you are over 18). Zoma Dental may need to communicate with your family in the following circumstances: Making or confirming appointments, discussing treatment needed or performed, or financial information.

Please indicate below the name(s) of people and their relationship to you, whom we may communicate with regarding your appointments, medical/dental concerns, and financial information:

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Patient Acknowledgement and Consent

I acknowledge that I have received a copy of your Notice of Privacy Practices and I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I also give consent to discuss my treatment, medical/dental concerns, and financial information with the individuals I have listed above.

Please sign this form below to acknowledge that you have reviewed our copy of the notice of privacy practices and consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

Patient Name: _____ Date: _____

Patient / Parent / Legal Guardian Signature: _____