DOUGLAS HOPPE, D.D.S.

1529 Kyle Street, Eaton Rapids, MI 48827 (517) 663-4911

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1916, ("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, 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 Signature (Parent)	Date	Patient Name (Please Print)

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 (Parent)	Date	Patient Name (Please Print)

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)