ALPHA OMEGA DENTAL CENTER, PLLC

Effective April 14, 2003, the new federal laws 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, 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: 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. It may also be used for education purposes.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have, today, reviewed a copy of our notice of privacy practices.

I, acknowledge that I have, today, reviewed a copy, for reading, of the Notice of Privacy Practices, or have had such policy read to me.

_____ _____ _____

Patient Signature Printed Patient Name Date

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 the proper treatment.

You also acknowledge and understand that Alpha Omega Dental Center, and Dr. Cynthia Wiggins are participating providers with Delta Dental and Blue Cross Blue Shield Dental Insurance policies as of November 19, 2014. Claims will be submitted to your insurance carriers on the date of service and you estimated co-pay and/or deductible will be collected on the date of service. Prior authorizations will be submitted with completion of a treatment plan so that you co-pays are as accurate as possible. Insurance carriers can change what they pay from what was noted on the prior authorization and if or when they do, it is beyond the control of this office. WE ARE NOT participating providers with any medical insurance carriers and payment in full for all medical treatment is mandatory on the date of service.

The parent who brings in their children for care is the party financially responsible for the account balance. Agreements for financial responsibility between separated and/or divorced parents are between the parents, and this office will not be in the middle of any disagreements. We also ask that you make arrangements for childcare unless pre-approved by Dr. Wiggins.

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. I understand that I am responsible for any outstanding balance after insurance has paid. I understand that any outstanding balance on my account will also have additional fees added for collection services, court costs, and no-show fees.

_____ _____ _____

Patient Signature Printed Patient Name Date

OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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_____ _____ _____

Printed Personnel Name Personnel Signature Date