Office of

Samuel J. Frydenlund, D.D.S., M.S.

Patient Acknowledgement and Consent

Effective April 14, 2003, the federal law known as Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that this office comply with certain rules regarding the maintenance and the privacy of your information we have collected and will collect in the future.

To comply with 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 us (in addition to our attempt to obtain your written acknowledgment as discussed above) 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 entities functions; identification of a missing person; a licensure investigation; 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

Please sign this form under the heading "acknowledgement" to recognize that you have received a copy of our notice of privacy practices today.

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

X_____ X_____ X_____

Patient Signature (Guardian if minor) | Patient Name (please print) | Date

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) | *Office Personnel (print name*

Date

Patient Consent

Please sign this form below under the heading "consent" to agree 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 necessary in connection with my treatment. I understand that such disclosures may not be the type listed above.

X_____ X_____ X_____

Patient Signature (Guardian if minor) | Patient Name (please print) | Date