ROBERT R. WATTS | DDS |

Cosmetic *and* Family Dentistry
Dental Sleep Disorder Therapy

Patient Acknowledgement 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 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.

PLEASE SIGN BELOW UNDER THE HEADING "ACKNOWLEDGEMENT" TO ACKNOWLEDGE 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 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 claim for payment of fees
- A third party payer's examination of our records
- A court order as part of a criminal investigation
- A review entity's function
- A defense to a claim challenging our professional competence
- 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.

PLEASE SIGN 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 ACKNOWLEDGEMENT

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

_____ _____

Patient or parent's signature — Patient name (please print)

_____

Date

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 or parent's signature — Patient name (please print)

_____

Date

For Office Use Only

_____Patient refused to sign _____An emergency situation prevented the patient from signing the acknowledgement.

_____The following circumstances prohibited the patient from signing the acknowledgement: _____

_____

Office Personnel Signature/Date _____