Posthumus and Biorn, Inc.

ACKNOWLEDGMENT AND CONSENT FOR TREATMENT AND NOTICE OF PRIVACY PRACTICES

Patient's Name: _____

Address: _____

Purpose of Consent: As required by HIPPA, we have prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records (or my child's records) to carryout treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

As a courtesy to our patients we do confirm all appointments 1 work day in advance to their scheduled appointment. By signing this you are willing to accept voicemail messages for appointment confirmations and receive information regarding treatment alternatives or other health & financial related benefits and services that may be of interest to you (and your family members). You also agree to accept unsecured email correspondence from St. Michael Dental Center.

Notice of Privacy Practices: You have the right to read our notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our notice of Privacy Practices, including any revisions of our Notice , at any time by contacting:

Contact Person: Dirk Posthumus, DDS

Telephone: 763-497-2040 Fax: 763-497-4418

Address: PO Box 279, St. Michael, MN 55376

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.