LOCUST LANE DENTAL GROUP

PATIENT CONSENT/ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Locust Lane Dental Group, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting Locust Lane Dental Group at (717) 652-6352. We will also post any revised notice in the office at Locust Lane Dental Group.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. According to the HIPPA privacy act, we have the right to refuse to treat you if you choose to refuse to disclose your protected health information.

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

X **Name** ______________________________ **X** **Date** _______________

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE CONSENT/ACKNOWLEDGEMENT OF NOTICE PRIVACY

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By signing below, I consent to Locust Lane Dental Group to submit all dental procedures to my current dental insurance listed in my file. I authorize release of any information relating to this claim to my insurance company and authorize payment directly to the below name dentist (Dr Glenn C Seitz) of the group insurance benefits otherwise payable to me.

X **Name** ______________________________ **X** **Date** ______________

The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, my insurance company may use and disclose Protected Health Information for treatment, payment and health care operations as described in its notice of Privacy Practices.

*************************Please see other side*******************************