Elan Dental Group
Expect Excellence

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. The Notice of Privacy Practices contains the information that HIPAA requires us to discuss regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment or insurance claims. For example, we may make a referral to or consult with another dentist or health care professional or make disclosures of your information in connection with providing and coordinating your dental treatment.

Patient/Legal Guardian/Power of Attorney Acknowledgment

Please sign this form to acknowledge that you have either received or reviewed a copy of our Notice of Privacy Practice.

Patient Name: _____ Date: _____

Print Name of Legal Guardian/POA: _____ Relation: _____

Signature: _____ Phone #: _____

I am also signing for my *minor* children: _____

Patient/Legal Guardian/Power of Attorney Consent

Please sign this form to consent to our disclosures of your information that we deem necessary in order to provide you with proper dental treatment.

Patient Name: _____ Date: _____

Print Name of Legal Guardian/POA: _____ Relation: _____

Signature: _____ Phone #: _____

I am also signing for my *minor* children: _____

I also give consent for my information to be discussed with the following individuals:

Name:	Date of Birth:	Type of Information that may be discussed:
_____		☐ Appointment ☐ Financial/Insurance ☐ Treatment
_____		☐ Appointment ☐ Financial/Insurance ☐ Treatment
_____		☐ Appointment ☐ Financial/Insurance ☐ Treatment
_____		☐ Appointment ☐ Financial/Insurance ☐ Treatment

I understand that this Consent will remain in effect unless a written cancellation has been provided to Moeller, PC.

For Office Use Only

☐ Patient refused to sign ☐ An emergency situation prevented the parent/guardian from signing this.

The following circumstances prohibited the patient from signing: _____
Date: _____

Office Personnel Signature: _____ Printed Name: _____