Dr. Kurt Schabes, D.D.S., PLC
Patient Acknowledgement and Consent Form

Existing Michigan Law requires us to 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 entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or 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 Name:_____**DOB:**_____**Date**_____
(Print name)

Responsibility of Patient

I am willing to take responsibility for my own health in such matters as weight, diet, smoking, exercise, alcohol and drug use and in following my doctor's instructions. I understand that abuse in any of these areas may adversely affect my health and treatment.

I have read and understand all of the above and agree to the terms set forth by Kurt E. Schabes, DDS, PLC. This release shall be effective only as long as is necessary to accomplish the purpose for which it is given or until it is specifically revoked in writing by the undersigned.

Signature_____**Date**:_____**Relationship**:_____

CONTACT INSTRUCTIONS

___YES I authorize Dr. Kurt E. Schabes and staff to leave information at the designated phone number and/or email address (below) regarding my care including, but not limited to, scheduled appointments, lab and x-ray results. Results may be given to the individuals answering the phone or left on the message machine.

___NO I do not authorize Dr. Kurt E. Schabes and staff to leave information regarding my healthcare or scheduled appointments on a message machine or given to any person except myself.

I authorize Dr. Kurt E. Schabes and staff to communicate any and all aspects of my dental care, including but not limited to financial information with:

Name:_____**Relationship:**_____

Name:_____**Relationship:**_____

I can be contacted at the following:

Telephone number:_____ **Email address:**_____

PATIENT CONSENT

I authorize Dr. Kurt E. Schabes and staff to use and disclose protected health information to carry out treatment, payment activities and healthcare operations that they deem necessary in order to provide proper treatment.
I understand that such disclosures may not be of the type listed above.

Name:_____**Relationship:**_____ **Date**: _____

I authorize Dr Kurt E. Schabes and staff to talk to my parent/guardian regarding my dental information and fees_____

Patient Refusal to Sign

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

_____ _____ **Date**_____
Office Personnel (signature) **Office Personnel (print name)**