Patient Consent Form

Dr. Kent N Nicklas, DDS Inc.
633 West Bagley Road
Berea, Oh 44017

I understand that, under the Health Insurance Portability & Accounting Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information can be and will be used to:

- **Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly**
- **Obtain payment from 3rd party payers.**
- **Conduct normal operations such as quality assessments & physicians certifications**

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand this may be updated or changed as deemed appropriate.

I understand I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME (please print)_____

SIGNATURE_____

RELATIONSHIP TO PATIENT_____

DATE:_____