Alchemy Acupuncture: Psychotherapy & Herbal Pharmacy

PATIENT CONSENT FORM

Our Patient Consent & Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. This protects your privacy regarding your health. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice Notebook that is posted in our Clinic Lobby.
- The practice reserves the right to change the Notice of Privacy Practices.
- We reserve the right to leave confidential messages (i.e. appointment reminders) on your telephone answering machine or voice mail. Please print the telephone number where you want to receive calls about your appointments if other than your home phone number:_____
- The patient may revoke this consent in writing at any time with the Privacy Officer (Clinic Manager) and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

I do hereby consent to take part in the treatment with the Psychotherapist/Acupuncturist named above. I understand that developing a treatment plan with this practitioner and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this practitioner. I agree to play an active role in this process. I am aware that I may stop my treatments with this practitioner at any time.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged directly for that appointment.

I request that payment of authorized benefits be made to the above-named practitioner on my behalf, for any services provided to me. I authorize any holder of clinical/medical and other information about me, to be released to my insurance company or other third party payer any information needed for the determination of benefits. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original. I understand that if payment for services I receive here is not made, the practitioner may stop my treatment.

I have read and understand the patient consent form: _____

Signature-Patient or representative

Relationship to patient (if other than patient):_____

Date:_____