Consent for Purposes of Treatment, Payment & Healthcare Operations for Capitol Wellness Center

I consent to the use or disclosure of my protected health information by Capitol Wellness Center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by Capitol Wellness Center may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Capitol Wellness Center is not required to agree to the restrictions that I may request. However, if Capitol Wellness Center agrees to a restriction that I request, the restriction is binding on Capitol Wellness Center. I have the right to revoke this consent, in writing, at any time, except to the extent that Capitol Wellness Center has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I agree to and acknowledge that I am responsible for all payments, including if or when my insurance carrier does not cover expenses and services.

I have been provided with a copy of the Notice of Privacy Practices of Capitol Wellness Center and understand that I have a right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Capitol Wellness Center.

Capitol Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office at Capitol Wellness Center and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority