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Consent For the Use and Disclosure of Health Treatment, Payment, or Healthcare Operations Information (HIPAA)

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

-A basis for planning my care and treatment.
-A means of communication among the many health professionals who contribute to my care.
-A source of information for applying my diagnosis and treatment information to my bill.
-A means by which a third-party payer can verify that services were actually provided.
-A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I have read the Notice of Privacy Practices, have had the opportunity to ask questions regarding its content and meaning and full understand it.

I understand I have the right:
-To object to the use of my health information for directory purposes.
-To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
-To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

_____ _____
Signature of Patient or Legal Representative Date

Office Protocols

1. I have been informed of all pertinent fees associated with my care, and that fees are payable in full at the time of treatment.

2. There is a 24-hour cancellation policy. I agree to call at least 24 hours in advance or I am responsible for the full fee of the missed appointment.

3. The fee for a returned check is $25.00, which I agree to pay in full.

4. I understand that acupuncture is not a substitute for conventional medical care.

Signature of Patient:_____