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PATIENT CONSENT FORM

I understand that, under the Health Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this form can 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 indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you or 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 that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

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

DESIGNATED METHOD OF CONDUCTING PATIENT:

Where may we contact you regarding your appointment and/or treatment?

Home ( ) Yes ( ) No Phone No. _____

Work ( ) Yes ( ) No Phone No. _____

Cell ( ) Yes ( ) No Phone No. _____

If we are unable to speak with you directly, may we leave a message?

Home ( ) Yes ( ) No **Work** ( ) Yes ( ) No **Cell** ( ) Yes ( ) No

Patient Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____