

Harmony Health Acupuncture And Herbs

Patient Privacy and Financial Policy Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health data about you. The notice contains a Patient Rights section describing your privileges under the law. You have the right to review our notice before signing this document. The terms of our notice may change. You may obtain a revised copy anytime 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. Such a revocation shall not affect any disclosures we have already made reliant 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 the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- Harmony Health Acupuncture and Herbs reserves the right to leave messages (i.e. appointment reminders) on your telephone answering machine or voice mail.
- Correspondence from Harmony Health Acupuncture And Herbs will be in a sealed envelope
- The patient may revoke this consent in writing at any time with the Clinic Manager; all future disclosures will then cease.
- The practice may condition treatment upon the execution of this consent.

This consent was signed by: _____ DATE: _____

Patient or Representative

Relationship to Patient (if not patient): _____

Witness: _____ DATE: _____

Patient Representative

Statement of Financial Policy

- There is a \$25 fee for all returned checks
- Please give us 24 hours notice prior to canceling appointments to avoid a \$25 cancellation fee

I have read and understand Harmony Health Acupuncture And Herbs' financial policy.

Patient Signature: _____

