WELL-BEING ACUPUNCTURE CENTER

Well Mind. Well Body. Well Soul. Well-Being.

HIPPA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and. Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protection of health information. I understand that this information 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.

Your office and its staff have informed me of the Notice of Privacy Practices that contain a more complete description of the uses and disclosures regarding my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that I may restrict how my private information is used or disclosed to carry out treatment, payment, or health care options. I understand you are not required to agree to my requested restrictions, but if you do are 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 replying on this consent.

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Patient Name (please print)

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Patient Signature or Patient Representative Date