Consent for Purposes of Treatment, Payment, and Healthcare Operations

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

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 health care operations of the practice. Health Sphere Wellness Center is not required to agree to the restrictions that I may request. However, if Health Sphere Wellness Center agrees to a restriction that I request, the restriction is binding on Health Sphere Wellness Center.

I have the right to revoke this consent in writing at any time, except to the extent that Health Sphere Wellness Center has taken action in compliance of this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physical therapist, another health care provider, a health plan, my employer or 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 understand I have a right to review Health Sphere Wellness Center's Notice of Privacy Practices prior to signing this document. Health Sphere Wellness Center's Notice of Privacy Practices has been provided me. 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 Health Sphere Wellness Center. The Notice of Privacy Practices for Health Sphere Wellness Center is also provided in the waiting area. The Notice of Privacy also describes my right and Health Sphere Wellness Center's duties with respect to my protected health information.

I understand that there is a 24-hour cancellation policy. If I need to cancel my appointment without 24-hour notice, I understand that I will pay a $25 cancellation fee.

Health Sphere 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 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Who referred you to our clinic?_____