NATURAL HEALTH CENTER, LLC

PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

This consent form, when signed, gives us permission to release necessary medical information to your medical insurance provider to process your claim, as well as to the pathologist, lab, or other doctor(s) who may be consulted in your diagnosis and treatment. Each of the above will also treat your information with the strictest confidence. This signed consent form gives us authorization to provide your information to a specific person other than yourself. Your medical information is otherwise confidential.

By signing below, you understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Natural Health Center, LLC (NHC) has a Notice of Privacy Practices and you have the opportunity to review this Notice and reserve the right to receive a printed copy upon request at anytime.
- NHC reserves the right to change the Notice of Privacy Practices. If we change our Notice, you may obtain a revised copy by contacting our office.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease, except for those disclosure that are required by law.
- NHC may alter provision of services upon the execution of this Consent.
- In addition, you acknowledge receipt of the NHC Notice of Privacy Practices provided to you today.

Do we have your permission to:

Consult within Natural Health Center? **Yes____No_____N/A____**

Leave a voice message on your answering machine at home/cell? **Yes____No_____N/A____**

Leave a message at your place of employment? **Yes____No_____N/A____**

Would you like to receive text message reminders? **Yes____No_____N/A____**

Discuss your medical condition with any member of your household? Yes____No_____N/A____

If yes, whom:_____

Relationship:_____

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Description of Personal Representative's Authority

_____ _____

Signature of Witness Date