Evenstar Acupuncture and Integrative Medicine Inc.

Patient Consent Form & Financial Policy

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. The terms of our notice may change. You may obtain a revised copy 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 in reliance 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
- Center for Acupuncture & Oriental Medicine reserves the right to leave messages (i.e. appointment reminders) on your telephone answering machine or voice mail.
- Correspondence from Center for Acupuncture & Oriental Medicine 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): _____
(Mother/Father/Guardian)

Witness: _____ Date: _____
(Practice Representative)

Statement of Financial Policy

- There is a $25.00 fee for all returned checks
- **Please give us 24 hours of notice prior to canceling appointments to avoid a $25.00 cancellation fee**
- We accept Visa, MasterCard & Discover

I have read & understand Evenstar Acupuncture and Integrative Medicine's financial policy.

Patient Signature: _____ Date: _____