PINNACLE ALLERGY CLINIC

RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM

Patient:_____DOB: _____

In the course of providing services to you, we create, receive and store protected health information (PHI) that identifies you. It is often necessary to use and disclose this PHI in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* (NOPP) you have been given describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this form. As described in our NOPP, the use and disclosure of your PHI for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your PHI for purposes of payment includes (1) our submission of your PHI to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your PHI to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our NOPP. Our NOPP will be updated whenever our privacy practices change. You can obtain an updated copy of the NOPP in our office.

When you sign this consent document, you signify that you agree that we can/will use and disclose your PHI to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices.*

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or other healthcare operations, but as described in our NOPP, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our NOPP describes how to ask for a restriction.

Patients in our practice may be contacted via email, cell phone and/or text messaging to remind you of an appointment, provide healthcare reminders/information and for patient account information. If at any time you provide an email, cell phone number or text address at which you may be contacted, you consent to receiving the message types described above from this practice.

_____ (Patient Initials) I consent to receive calls and/or text messages from this practice at my cell phone and any other number forwarded or transferred to that number, or emails, to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders, healthcare communications/information, and patient account information unless I request a change in writing.

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request healthcare and/or financial information. Under the requirements for HIPPA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your healthcare and/or financial information released to any family members, you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Pinnacle Allergy Clinic, PLLC to release my healthcare and/or financial information to the following individuals:

1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

I have read the NOPP of this office and understand it. I consent to the use and disclosure of my PHI for purposes of treatment, payment and healthcare operations.

_____ _____

Patient Name Date

If signing as a personal representative of this patient, describe the relationship to the patient:

_____ _____

Print Name Relationship to Patient