Consent to Treatment

I, the undersigned, consent to the treatment necessary for the care of the below listed patient. I hereby authorize release of any or all medical records to the referring physician my insurance carries or those involved in payment of my account. Further, I acknowledge full financial responsibility for any services rendered by Flourish Wellness DH LLC and understand that payment of charges incurred in this office is due at the time of service. In the event an account is not paid within 90 days, the undersigned agrees to pay all cost of collection including attorney's fees and hereby waives all right of exemption under the constitution of the State of Alabama.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of use or disclosure, we will elaborate on the meaning and provide more specific examples upon request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose your information will fall within one of the categories.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, and insurance company, or third party. For example: We may disclose your medical record to an insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your care, such as family members, clergy, or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other persons that are part of your care for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group that allow to help you, as well as all employees, staff, and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at this practice. We need this record in order to provide you with quality care and to comply with legal requirements. This notice applies to all records of care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of this notice that is currently in effect. Other ways we may use or disclose your protected health information include: appointment reminders ; newsletters; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners, and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the president and other public health risks; and workman's compensation.

Notice of Individual Rights

You have the following rights regarding medical information we maintain about you:

Right to an Accounting Disclosure: You have the right to request an "accounting disclosure." This is a list of the disclosures we made of medical information about you.

Right to Amend: If you feel that the medical information that we have about you is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice.

Right to Inspect and Copy: You have the right to inspect and copy medical information used to make decisions about your care. We withhold the right to deny your request to inspect and copy in certain, but limited circumstances.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must submit your request in writing and specify the manner and location you wish to be contacted.

Right to Request Restrictions: You have the right to request restrictions or limitations on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do not agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

CHANGES TO THIS NOTICE: We reserve the right to change this notice.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the law will be made only with your written authorization. If you provide us with the permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Patient Printed Name Patient Date of Birth