# Integrative Health & Wellness Clinic, LLC

**Acknowledgement and Consent**

*Patient: Please initial each paragraph that applies to you*

Section I. Receipt of Notice of Privacy Practices

_____ I acknowledge I received a copy of Integrative Health & Wellness Clinic *Notice of Privacy Practices*, effective April 1, 2020, which describes the ways in which Integrative Health & Wellness Clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practices.

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Section II. Text Appointment Reminders

____ I acknowledge I received, reviewed, and understand Integrative Health & Wellness Clinic Text Appointment Reminders – Terms of Use and Conditions, effective April 1, 2020. I was given the opportunity to ask questions, and all questions have been answered to my satisfaction.

____ I consent to receiving appointment reminders by text from Integrative Health & Wellness Clinic to the following cell phone number _____.

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Section III. Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

____ I consent to receiving unsecure instructions and other healthcare communications at the email or phone number I have provided below, whether by text or telephone call. Such messages may be left on my answering machine or voice mail, and may include, but not be limited to: post-procedure instructions, follow-up instructions, test results, and educational information. Such messages may include personal health information, the confidentiality of which is otherwise protected under the Health Information Portability and Accountability Act. You may opt out of these communications at any time. Standard text messaging rates may apply as provided in your wireless plan.

Phone number: _____

Phone number: _____

____ I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

# Integrative Health & Wellness Clinic, LLC

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

____ I understand I may revoke this consent in writing, except to the extent that disclosure of Protected Health Information I has already been made in reliance up this consent.

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Section IV. Laboratory and Other Diagnostic Tests

____ I understand and acknowledge that charges for laboratory or other diagnostic testing may not be covered under my health or medical insurance.

____ I understand that knowledge of eligibility, covered benefits, and medically necessary procedures is my responsibility and I will contact my insurance company for questions I may have regarding coverage.

____ I understand I am responsible for any charges not covered by my plan.

____ I authorize Integrative Health & Wellness Clinic to conduct laboratory testing and/or provide referrals for other diagnostic tests.

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_____ _____

Signature Print Name if different than Patient

_____ Check relationship to patient:

Date __ Self __ Parent __ Legal Guardian

# Integrative Health & Wellness Clinic, LLC

For Integrative Health & Wellness Clinic Use Only

We attempted to obtain written acknowledgement of receipt foo u Notice of Privacy Practices, but acknowledgement could not be obtained because (Please check all that apply):

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

Staff Name: _____ Title: _____

Signature: _____ Date: _____