

The Healing Garden

mend the body, nurture the soul



Client Contact Information

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Email: _____

Would you like to be on our mailing list to be notified of specials and events? **Yes** **No**

Phone: (Day) _____ (Evening) _____

Spouse: _____ Phone: _____

Occupation: _____ Employer _____

Who are you seeing today? _____

How did you hear about us? _____

106 W North Bend Way North Bend WA 98045 425-292-0402

TheHealingGardenDaySpa.com

Client Consent for the Purposes of Treatment, Payment and Health Care Operations

I give consent to The Healing Garden Massage Therapy for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me and for general administrative operations of the practice.

I understand that I have the right to request restrictions on the use and disclosure of my PHI, but the practice is not required to agree to these restrictions. If the practice agrees with my restrictions, the restriction is binding on the practice.

You may contact me for appointment reminders, schedule changes, or other needs by the following methods (Check only those methods by which you desire to be contacted):

Home Telephone: () Work Telephone: () Cell Phone: () e-mail: ()

Home Address: () Work Address: ()

Marketing: Occasionally we send out newsletters, announcements and special occasion cards. If you do not wish to receive these, please check here: ()

I have received a copy of the Privacy Policies Notice. I have read the Notice and understand this authorization form. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. I also understand that I may revoke this authorization at any time by notifying the practitioner in writing.

Signature

Date

Print Name

Privacy Policies Notice

We are dedicated to providing top-quality service. Protecting your privacy is paramount and we have implemented procedures to safeguard your information included in your files. Computerized files can only be accessed with a password; and all paperwork is kept in a locked filing cabinet.

This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Personal and Protected Health Information

We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:

- * We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
- * We may disclose your PHI to any third party you designate in writing.
- * We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
- * We may disclose your PHI if we ever sell or transfer our practice.
- * We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
- * We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
- * We may disclose your PHI to a health oversight agency for activities authorized by law.
- * We may disclose your PHI as required by a court or administrative order, or under certain circumstances in response to a subpoena, discovery request or other legal process.
- * We may release your PHI as necessary to comply with laws relating to Workers' Compensation or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
- * We may disclose your PHI to a HIPAA certified Business Associate (a person or organization that performs a function or activity on behalf of the practice that involves the use or disclosure of PHI, such as a billing services company or another practitioner who is involved in your health care).
- * Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
- * We may use or disclose your PHI when required by law.
- * We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Please note your rights regarding this information:

1. You are entitled to inspect and receive copies of your records.
2. You are entitled make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have the right to disagree with the practitioner's refusal of inclusion.