Hair Analysis
Wellness & Prevention
Learning Evaluations
Nutritional Counseling
Saliva Hormone Testing

OPTIONS CENTER
For Health & Education Inc

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CLIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT HEALTHCARE OPERATIONS AND PAYMENT

I, _____, herby state that by signing this Consent, I acknowledge and agree as follows:

1) The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information [PHI] necessary for the Practice to provide help to me, and also necessary for the Practice to obtain payment for that help and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3) I understand that, and consent to, the following reminders that may be used by the Practice:
   a) A post card mailed to me at the address provided by me;
   b) Telephoning my home, work or cell phone and leaving a message on my answering machine or with the individual answering the phone [whatever is checked on the client statement.
4) The Practice may use and/or disclose my PHI [which includes information about my health or condition and the treatment provided to me] in order for the Practice to care for me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out care, payment and any other necessary operations.
6) I understand that this Consent is valid for the future with no time limits. I further understand that I have the right to revoke this Consent, in writing , at any time for all FUTURE transactions with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.
7) I understand that if I revoke the Consent at any time, the Practice has the right to refuse to give care to me.
8) I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, the Practice will not care for me.

I have read and understand the foregoing notice, and all of my question have been answered to my full satisfaction in a way that I can understand.

_____ _____ Date Signed:_____
Name of Individual [printed] Signature of Individual

_____ _____ Witness: _____
Signature of Legal Representative Relationship
[e.g., Parent if a minor, Attorney-in-Fact, Guardian

Cancellation Policy:
If I must cancel an appointment, I agree to call 24 hours prior to my scheduled time. If I cancel later than that or do not show for a scheduled appointment, I agree to pay the usual amount of the appointment; and I understand I may be requested to prepay future scheduled appointments. Please call between the hours of 8:00AM-6:00PM.

I HAVE READ THE ABOAVE CANCELLATION POLICY AND AGREE TO ABIDE BY IT.

Signature of Client:_____ Date Signed:_____