Silver Leaf
NATURAL MEDICINE

Patient Information

Last Name: _____ First Name: _____

Address: _____City: _____State: _____ Zip:_____

Home Phone: _____Work Phone: _____

Cell Phone: _____

Email: _____

Birthdate (MM/DD/YYYY): _____Age: _____

Height: _____Weight: _____ Sex: M F Other _____

Occupation:_____

Marital Status: (circle) Married Domestic Partnership Single Other

Emergency Contact: _____ Relationship: _____

Phone: _____

Are you currently taking any medications? If so, please list:

How did you find Silver Leaf Natural Medicine?

I have read and agree with the following Silver Leaf Natural Medicine: Office Policies, Privacy Statement, and HIPAA Consent Forms:

_____ _____
patient signature date

Patient's HIPAA Acknowledgement & Consent

I, _____, give consent to Silver Leaf Natural Medicine for the use and disclosure of my Protected Health Information (PHI) for these specific purposes:

1. Providing treatment to me.
2. Collecting and processing payment for the services this office has rendered to me.
3. The general administrative operations this practice provides to me.

The Purpose of this Consent:

Protected Health Information (PHI) is any information that includes individually identifiable demographic information, including information gathered by this practice as it relates to my past, present, and future healthcare services and financial transactions. This practice may use my PHI for healthcare operations purposes, including quality assessment activities, credentialing, business management, marketing, and other general operations procedures or activities.

I understand I have the right to request or put restrictions on the use and disclosure of my PHI for the purposes of treatment, payment of healthcare operations of the Natural Medicine practice, but the practice is not required to agree to these restrictions. However, if Silver Leaf agrees to a restriction that I request, the restriction is binding on the practice.

I understand I have the right to restrict certain disclosures to my health insurance provider (if applicable) regarding products or services for which I pay out of pocket and in full at the time of service.

I understand my authorization is required for uses or disclosures of my PHI for marketing purposes, for any disclosures that constitute a sale of PHI, and for any other uses/disclosures not described in our Notice of Privacy Policies.

I understand that I have the right to be notified of any breach of my unsecured PHI.

I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of Silver Leaf Natural Medicine before I sign this consent form regarding the use and disclosures of my Protected Health Information.

I understand that I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has acted in reliance on this consent.

_____ _____

signature of patient or personal representative date

_____

description of personal representative's authority

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Our Privacy Policies

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with other medical practitioners that you authorize.

Safeguards in place at our office include:

● Limited access to facilities where information is stored.
● Policies and procedures for handling information.
● Requirements for third parties to contractually comply with privacy laws.
● All medical files and records (including email, regular mail, telephone) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include nonpublic personal information:
● About your financial transactions with us (billing transactions).
● From your medical history, treatment notes, all test results, and any letters, emails or telephone conversations to or from other healthcare practitioners.
● From healthcare providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you e.g. your name, address, Social Security number, etc.). We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during business hours at 828.254.0353.