NPP acknowledgment

Patient: ______________________________

I understand that as part of my healthcare, Healing Spirit Integrative Health Center, HSIHC, will use and disclose my health information.

I understand that my health information may include information received by or created by HSIHC and that this information may be in written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that HSIHC may use and disclose my health information in order to:

- make decisions about my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my provider's efforts to provide me with and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how HSIHC will handle health information about me. This written description is known as the Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other personnel of HSIHC and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised at any time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of HSIHC's Notice of Privacy Practices will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that HSIHC is not required to agree to the restrictions I may request.

I acknowledge that I have received and/or been offered a copy of HSIHC's Notice of Privacy Practices.

____	__________________
Signature of patient or legal representative	Date
____	___________________
Printed name of patient or legal representative	Patient's date of birth

** FOR OFFICIAL USE ONLY**

Copy offered to patient ______ Scanned into EHR by: ______ on ____________