

Receipt of Notice of Privacy Policies & Consent Form

2808 East N. Ave. Anderson, SC 29625 / 900-A Greenville Dr. Williamston, SC 29697 / 518 College Ave. Clemson, SC 29631
Phone: (864) 226-6041 Fax: (864) 226-1232

Patient Name: _____

Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practice*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosure of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practice*. Our *Notice of Privacy Practice* will be updated whenever our privacy practices change. You can get an updated copy from our website or one of our office locations.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the use of disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. As described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practice*.

May we phone, email, or send a text to you to confirm appointments? **YES / NO**

May we leave a message on your answering machine at home or on your cell phone? **YES / NO**

May we discuss your medical condition with any member of your family? **YES / NO**

If YES, please name the members allowed: _____

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient

Print Name

Source of Authority