Pate Acupuncture & Chinese Medicine LLC
Lisa Pate L.Ac.
1222 SE Division
Portland OR 97202

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document "I" & "my" refer to the patient. "L.Ac." refers Lisa Pate, L.Ac.

I consent to the use or disclosure of my protected health information by L.Ac. for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of L.Ac. I understand that the analysis, diagnosis, or treatment of me by L.Ac. may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. L.Ac. is not required to agree to the restrictions that I may request. However, if L.Ac. agrees to a restriction that I request, the restriction is binding on L.Ac. I have the right to revoke this consent, in writing, at any time except to the extent that L.Ac. has taken action in reliance on this consent.

My Protected Health Information means health information, including my demographic information, collected from me & created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me; or there is a reasonable basis to believe the information may identify me.

I have a right to the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices for L.Ac. is posted in the waiting room of the clinic. The Notice of Privacy Practices describes the types of uses & disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of L.Ac. This Notice of Privacy Practices also describes my rights & duties while receiving care from the L.Ac. with respect to my protected health information.

The L.Ac. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of Privacy Practices by calling the office of L.Ac. & requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____ _____

Signature of patient or personal representative Date

_____

Printed name