Arlington Family Healthcare
Receipt of Notice of Privacy Policies & Consent Form
P.O. Box 314, Arlington, OR 97812
Phone: (541) 454-2888

Patient Name_____

Patient Address _____

Patient Phone Number _____

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 Practices,** the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures 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 Practices**. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

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 uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our **Notice of Privacy Practices,** we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for this 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 Practices* from Arlington Family Healthcare.

_____ _____

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 the Patient Print Name