Wilder Health ~ Acupuncture and Herbal Medicine
102 N Main St. Halfway, OR 97834 (541) 406-0615

HIPAA Consent Form (Health Insurance Portability and Accountability Act)

I give Hopi Wilder,L.Ac. my consent to use or disclose my protected health information to carry out my treatment, to obtain payment, and for health care operations such as quality reviews.

I have been informed that I may review the clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand that this clinic has the right to change their privacy practices and that I may obtain my revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the clinic is not required to agree to the request. If the clinic agrees to my requested restriction, they must follow the restriction(s).

Complaints concerning my protected health information should be filed in writing with the clinic owner.

Insurance Assignment and Release

I assign all insurance benefits, if any, otherwise payable to me, to Hopi Wilder, L.Ac. for services rendered. I understand that I am financially responsible for all charges regardless of insurance coverage. I understand that my signature authorizes the release of any information and/or records necessary to my insurance company. It is understood that all accounts are due and payable at the time service is rendered. **It is further understood that if at least 24 hours notice is not given at cancellation of any appointment, I will be charged for time reserved. I understand I am responsible for these charges and my insurance will not be billed.**

_____Date _____
Patient Name

_____Date_____
Patient or Guardian Signature