HIPPA PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives patients the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

**I wish to be contacted in the following manner (check all that apply):**

□ Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
□ O.K. to leave a message with detailed information

□ Leave message with call back number only

□ Work Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
□ O.K. to leave a message with detailed information

□ Leave message with call back number only

□ Mobile Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ O.K. to leave a message with detailed information

□ Leave message with call back number only

Written Communication

□ email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ O.K. to send a message with detailed information

□ Send message with return email address only

□ Prefer mail to my home address:

□ Prefer faxes to this number:

□ Prefer mail to my work/office address

Date\_\_\_\_\_\_\_\_\_\_\_\_Print and sign name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S AUTHORIZATION

Payment is due at the time service is rendered.

**I will pay in full without 24-hour notice for cancellations.**

The issue of insurance payment is between me and my insurance carrier.

I agree to promptly pay all charges for services rendered and accept legal responsibility for any and all charges for the patient named above. I authorize treatment with acupuncture, bodywork, gua sha, cupping and Chinese herbs by Barbra Esher, L.AC.

I understand that the practitioner is not a primary care health provider and does not advocate this in lieu of medical treatment. I authorize the release of any necessary information including medical records to my insurance carrier. I permit a copy of this authorization to be used in the place of the original.

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print and sign name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_