TAO OF HEALING

Patient's Consent for the Purposes of Treatment, Payment and Healthcare Operations
Acknowledgement of Receipt of Notice of Privacy Practices

With my consent, American Taoist Healing Center may use and disclose **P**rotected **H**ealth **I**nformation (PHI) about me to carry out **t**reatment, **p**ayment and healthcare **o**perations (TPO). Please refer to American Taoist Healing Center's Notice of Privacy Practices for a more complete description of such uses.

I have the right to review the Notice of Privacy Practices prior to signing this consent. American Taoist Healing Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to American Taoist Healing Center Privacy Officer.

With my consent, American Taoist Healing Center may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and return calls requesting a call back.

By signing this form, I am consenting to American Taoist Healing Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, American Taoist Healing Center may decline to provide treatment to me.

_____ _____
Print Patient's Name Patient's Signature

_____
Date

Advisement as to the importance of consulting with a licensed physician

New York State law requires that all patients sign the following form:

We, the undersigned, do affirm that _____ has been advised by the American Taoist Healing Center to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

_____ _____
(Patient Signature) Date

_____ _____
(ATHC Signature) Date

Consent for Recording

I give consent for the Tao of Healing to record my conversations with Dr Lu. These recordings will be used for documentation and training purposes only. No name or other identifiable information will be disclosed, my privacy will be protected at all times.

_____ _____
(Patient Signature) Date

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