

HIPPA ACKNOWLEDGEMENT

I have received a copy of this office's Notice of Privacy Practices and I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations as set out in the Notice.

***Purpose of Consent**

By signing this form, you will consent to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations as set out in the attached "Notice of Privacy" and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

***Right to Revoke**

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed in our Notice of Privacy Practices. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating if you revoke this consent.

I, _____, Date of birth _____, have had full opportunity to read and consider the contents of t

(Print Patient Name)

this consent form and your notice of privacy practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations as set out in notice.

Date Signed: _____

(Patient Signature)

*If signed by parent, guardian, or personal representative on behalf of the patient, complete the following:

Parent, Guardian, or Representative Name Relationship to Patient Date Signed

CONSENT FOR TREATMENT: I hereby consent to treatment to be preformed by Dr. Gonzalez and his associates. Furthermore, I understand the possible complications that might occur from a proposed treatment and that a perfect result cannot be guaranteed. If it becomes necessary to turn this account over for collections, I agree to pay all attorney's fees, court costs, and all other costs of collection up to 40% of the balance due on my account. The undersigned agrees to pay for all services rendered. This form was signed in Shelby County and all services are performed in Shelby County.

By signing this form, I understand that I am responsible for any balance on this account including any balance not covered or paid by my insurance provider.

Person Responsible For this Account: **Signature** _____ Date _____
(Parent or Guardian if Patient is a Minor)