Beyond Health LLC

Making Your Health Our First Priority

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ACKNOWLEDGEMENT AND CONSENT

I understand that Beyond Health LLC (also referred as Family medicine and skin care clinic) will use and disclose health information about me.

I understand and agree that Beyond Health LLC may use and disclose my health information in order to:

1) Make decisions about and plan for my care and treatment.
2) Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
3) Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
4) Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.

I also understand that I have the right to receive and review a written description of how Beyond Health LLC will handle information about me. This written description is known as a Notice Of Privacy Practices and describes the uses and disclosures of health information made, and the information practices followed by the employees, staff and other office personnel of Beyond health LLC, and my rights regarding my health information.

I understand that the Notice Of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice Of Privacy Practices, and I understand that Beyond Health LLC is not required by law to agree to such requests.

HIPAA Notice of Privacy Practices Acknowledgment

I acknowledge that I have received, reviewed, or been offered access to the **Notice of Privacy Practices** for Beyond Health Family Medicine Clinic. This notice explains how my medical information may be used and disclosed, my privacy rights under HIPAA, and how I may obtain copies of my health information.

I understand that Beyond Health Family Medicine Clinic reserves the right to change its privacy practices as permitted by law and will make any updated notice available upon request and on the clinic website.

I consent to communications from Beyond Health Family Medicine Clinic regarding appointments, billing, care coordination, and follow-up care by phone, voicemail, patient portal, email, or SMS when appropriate.

I understand I may revoke communication preferences in writing, except where already relied upon for treatment or operations.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of The Notice Of Privacy Practices.

Patient Name: ____________________________

Signature: _______________________________

Date: ___________________________________

If signed by personal representative:

Name: __________________________________

Relationship to Patient: _________________