HIPAA CONSENT FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Advanced Counseling** (also DBA Communicating Love) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **ADVANCED COUNSELING**. I understand that using my insurance or related health treatment may require a Mental Health Diagnosis.

I understand Rodney Limb of Advanced Counseling may consult with other health care practitioners regarding your health concerns with-in the office and association with Provencia. In the event you seek services from those associated with Provencia you are consenting to open and free discussion regarding the assessment and planning and treatment as understood for your most efficient and effective care provided to you. In any event you may need Urgent Services your confidentiality may be breached for the purposes of helping you obtain your requested or associated needs.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **ADVANCED COUNSELING** is not required to agree to the restrictions that I may request. However, if **ADVANCED COUNSELING** agrees to a restriction that I request, the restriction is binding on **ADVANCED COUNSELING** staff and Rod Limb.
I have the right to revoke this consent, in writing, at any time, except to the extent that Rodney Limb or **ADVANCED COUNSELING** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **ADVANCED COUNSELINGS** Notice of Privacy Practices prior to signing this document. The **ADVANCED COUNSELING** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **ADVANCED COUNSELING**. The Notice of Privacy Practices for **ADVANCED COUNSELING** is also provided on the wall in the office waiting room. This Notice of Privacy Practices also describes my rights and **ADVANCED COUNSELING** duties with respect to my protected health information.

ADVANCED COUNSELING reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. Changes will be posted and kept up to date on the www.CommunicatingLove.com web site. I may obtain a revised notice of privacy practices by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.

Print Patient Name: ______________________________________ **Date:** ____________________
Signature of Patient or Personal Representative   Personal Representative's relation/authority to Patient

Sign: ______________________________________   ______________________________________

If you want to learn more about HIPAA go to: http://www.hhs.gov/

Last revised 4-25-2013