



# Center for Integrated Eastern Medicine

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## Consent for Purposes of Treatment, Payment & Healthcare Operations (8/06)

In this document, "I" and "my" refer to the patient,  
and "Acupuncturist" refers to Center for Integrated Eastern Medicine.

I consent to the use or disclosure of my protected health information by Acupuncturist for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Acupuncturist. I understand that analysis, diagnosis or treatment of me by Acupuncturist may be conditioned upon my consent as evidenced by my signature below.

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. Acupuncturist is not required to agree to the restrictions that I may request. However, if Acupuncturist agrees to a restriction that I request, the restriction is binding on Acupuncturist.

I have the right to revoke this consent, in writing, at any time, except to the extent that Acupuncturist 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 have been provided with a copy of the Notice of Privacy Practices of Acupuncturist and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. 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 Acupuncturist. The Notice of Privacy Practices for Acupuncturist is also posted in the waiting room. This Notice of Privacy Practices also describes my rights and duties of the Acupuncturist with respect to my protected health information.

Acupuncturist reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Acupuncturist and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I also assign all benefits to the Provider. I acknowledge that my signature on this document authorizes the submission of claims without obtaining my signature on each and every claim submitted.

**Payment/Insurance:** Payments are due at the time of service. However, if you are on a treatment plan that requires regular scheduling, we will schedule your treatments in advance. To reduce unnecessary wait time and to reduce costs to you, we ask that payment be made in advance for treatment plans. Missed appointments will be charged a no show fee if there is no 24 hour notice given. This fee is \$30 if you cancel the day of your appointment or do not show up.

If you are relying on insurance to pay for your treatment, please note: **Insurance companies do not guarantee payment.** Therefore, you are the primary one responsible to make sure payment is made by either by you or your insurance. As a courtesy we will contact your insurance company to verify your benefits. However, this does not guarantee that information we receive from your insurance company is accurate, nor does this guarantee payment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date of Signing

\_\_\_\_\_  
Description of Personal Representative's Authority

