Reincke Vein center

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Reincke Vein Centers to use and disclose my protected health information (PHI) to carry out the following:

- Treatment, including direct and indirect treatment by others healthcare providers involved in my treatment
- Obtaining payment from third party payer (e.g. my insurance company)
- The day-to-day healthcare operations of Reincke Vein Centers I have also been informed of, and given the right to review and secure a copy of the Reincke Vein Centers Privacy Statement, which contain a more complete description of the uses and disclosures of my PHI an my rights under HIPAA. I understand that Reincke Vein Centers reserves the right to change the terms of this notice at any time and that I may contact Reincke Vein Centers at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date is not affected.

_________________________________ _________

Patient or Responsible Party Signature Date

Appointment Cancellation Policy

I have read and agree to the cancellation Policy of the practice that states I may be assessed a fee if I do not give proper notice of cancellation of an appointment or procedure.

_________________________________ _________

Patient or Responsible Party Signature Date

Communication Consent

I agree to be contacted via phone, text and/or email in relation to treatment services and/or appointments.

_________________________________ _________

Patient or Responsible Party Signature Date

Optional Consent

I allow Reincke Vein Centers to disclose treatment, payment, and/or healthcare information to the following individuals:

Full name:__________________________________ Relationship:_________________

Full name:__________________________________ Relationship:_________________

Full name:__________________________________ Relationship:_________________

_________________________________ _________

Patient or Responsible Party Signature Date