PRIVACY POLICY
HEALING TRANSFORMATIONS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
I understand that as part of my healthcare, HealingTransformations originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment m **I understand that this information serves as:**

- A basis for planning my care and treatment. This information may be used to consult with other practitioners anonymously only for educational purposes and to ensure appropriate diagnosis and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that HealingTransformations is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that HealingTransformations has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Financial Agreement

HealingTransformations requires payment at the time of service. If your insurance covers acupuncture you may request a super-bill. You are responsible for billing your insurance company to be reimbursed for services.

Late Cancellations and No-Shows: Patients who reserve an appointment with a provider and fail to cancel within 24 hours or do not show up for a scheduled appointment will assess a charge.

I have read and understand my rights regarding privacy of information and under which conditions this information is shared with others. I have read and understand the financial agreement.

Signature: _____ Date: _____

Print Name: _____
A copy of your patient rights and agreements are available upon request.