ACKNOWLEDGEMENT & CONSENT

I understand that BehavioralHealthcare Northwest, PC (BHN) may use and disclose health information about me as deemed necessary by BHN or the provider. I understand that my health information may include information both created and received by the practice; it may be in the form of written or electronic records, or spoken words; it may include information about my health history, health status, symptoms, examinations, test results, diagnoses treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree thatBHN may use and disclose my health information in order to:

1. make decisions about my plan for my care and treatment
2. refer to, consult with, coordinate among, and/or 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 any portion of my health care
4. perform various office, administration 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 BHN will handle health information about me. This written description is known as a **Notice of Privacy Practices**, and is a detailed description of the possible uses and disclosures of health information made, and the information privacy practices followed by the employees, staff, and other office personnel of this practice, and rights regarding health information.

I understand the 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 also understand that a copy or a summary of the most current version of this Notice of Privacy Practices in effect will be available upon request, or located in the waiting/reception area.

I understand that I have the right to request 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 this practice is not required by law to agree to such requests.

By signing below, I agree to be seen as a patient at BHN, that I have reviewed and understand the information above, and that if requested, I have received a copy of the Notice of Privacy Practices.

Patient Signature: ____ **Date:**______________

Patient Printed Name: ____

-or-

Patient Representative: _____________________________________ Date:______________

Description of Representative's Authority:____