LOIS THOMSON BOWERSOCK & associates, llc

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CONSENT FORM

HIPAA Policy Notice

Notice of Privacy Practices of LOIS THOMSON BOWERSOCK & ASSOCIATES, LLC and Lois Thomson Bowersock, LCDC, NCAC I, ICADC, ADC III, CET, II Effective April 14, 2003; Revised January 1, 2022.

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. This Notice contains a Client's Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. Due to HIPAA, the following information must be updated by each Client annually.

I, the Client understand that:

- Protected Health Information (PHI) may be disclosed or used for treatment, payment, or other healthcare operations.
- Lois Thomson Bowersock & Associates, LLC has a Notice of Privacy Practices and the Client has the opportunity to review the Notice.
- The Client can view and download the Privacy Practices of Lois Thomson Bowersock & Associates, LLC at: www.loisbowersock.com.
- Lois Thomson Bowersock & Associates, LLC has the right to change the Notice of Privacy Policies.
- The Client has the right to restrict the uses of their information but Lois Thomson Bowersock & Associates, LLC does not have to agree to those restrictions.
- The Client may revoke this consent at any time and all future disclosures will then cease.
- Lois Thomson Bowersock & Associates, LLC may condition treatment upon the execution of this consent.

By signing, I hereby authorize Lois Thomson Bowersock & Associates, LLC to release my Protected Health Information (PHI) or insurance information as necessary to process my medical claims and coordinate, or manage my behavioral healthcare.

Signature of Client or Legal Representative

Printed Name of Client or Legal Representative

Witnessed

Date

I have reviewed the Notice of Privacy Practices of Lois Thomson Bowersock & Associates, LLC, which explains how my Protected Health Information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Persons authorized to receive my Protected Health Information:

Name	Phone	Email
Name	**Phone**	**Email**

Authorization for Lois Thomson Bowersock & Associates, LLC to communicate with you via the methods indicated:

I consent to be contacted by e-mail. ☐ Yes ☐ No

Email address

I consent to be contacted by mail via US postal service. ☐ Yes ☐ No

Street address **Apt #**

City **State** **Zip code**

I consent to be contacted by phone. ☐ Yes ☐ No

Cell **Work** **Other**

To communicate with you via telephone messages, check beside your preference:

It is okay to leave messages.	☐ Yes	☐ No
Do not leave any messages at all.	☐ Yes	☐ No

Note: Federal law restricts our ability to communicate with you without your consent.

Signature of Client / Parent if Minor

Relationship to Client

Printed Name of Client

Printed Name of Parent if Minor

Date

Changes to this document must be submitted in writing. This form is in compliance with HIPAA guidelines.
A copy of these guidelines is available upon request or may be obtained at www.loisbowersock.com