Acknowledgment and Consent

By signing below, I acknowledge that I have been offered a copy of (Insert Provider Name), "Notice of Privacy Practices". I have therefore been advised of how health information about me may be used and disclosed by (Insert Provider Name). Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of (Insert Provider Name).

With my consent, (Insert Provider Name), may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and health care options (TPO).

With my consent, (Insert Provider Name), may initiate a complaint to the Insurance Commissioner for any reason on my behalf.

With my consent, (Insert Provider Name), may deposit checks received on my behalf when made out to the Policy holder and received by this office.

With my consent, (Insert Provider Name)., may call my home or other designated location and leave messages on voice mail or discuss in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results.

With my consent, (Insert Provider Name), may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this informed Consent, you state: I understand the information about my treatment in the weight management program offered by the center identified below is shared, from time to time, with obesity researchers, medical scientists, and developers of weight management treatment. So research, science and the weight management industry may learn and benefit from my treatment and the treatment of others, I give permission for data regarding my treatment to be entered into a national database. I understand that strict confidentiality for the identities and individual records of patients in the database will be maintained. I also give local and national program staff permission to contact me by mail or telephone after my initial period of treatment to obtain information about my health and weight status. Should the results of my treatment or any aspect of it be published, all reasonable precautions will be taken to protect my anonymity.

Patient Name: _____

Signature of patient: _____

Date: _____

A photo copy of this assignment shall be considered as effective and valid as the original.