

Michelle Graves, L.Ac.
Summary and Acknowledgement of Receipt of Notice of Privacy Practices

1. Michelle Graves L.Ac.'s (the Practice) Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, obtain payment for that treatment, and to carry out its healthcare operation. The Practice explained to me that the Privacy Notice will be available to me at any future appointment and at my request at any other time.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with applicable law.
3. I understand, and consent to, the following communication that may be used by the Practice:
 - a) Cards, letters, or other written information mailed to me at the address provided by me.
 - b) Telephoning and leaving a message on my answering machine, voicemail, or with the individual answering the phone.
 - c) Sending electronic mail to the address provided by me.
4. The Practice may maintain a directory of and a sign-in log for individuals seeking care and treatment in the office. This information may be seen by, and is accessible to others who are seeking or services in the Practice's office.
5. The Practice may use and/or disclose my PHI for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific healthcare operations.
6. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, the restriction is binding on the Practice.
7. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

I acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Michelle Graves, L.Ac., by phone at (415) 677-9900. Signature below is acknowledgment that you have received this Notice of Privacy Practice and that you have read and understand the foregoing notice, Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

Name (Printed)

Dated Signed

Signature