LEICESTER SPINE AND WELLNESS CENTER
1103 MAIN ST. LEICESTER MA 01524
PH:(508) 892-8150 FAX:(508) 892-0372

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT & CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct , plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment.
*Obtain payment from third party payers.
*conduct normal health care operations such as quality assessment and physician certifications.

I have received , read , and understand Leicester Spine & Wellness Center's Notice of Privacy Practices containing a more complete description of the use and disclosures of my health information. I understand that Leicester Spine & Wellness Center has the right to change its Notice of Privacy Practices, and that I may contact the office at any time to obtain a copy of the current Notice of Privacy Practices.

I understand that I may request in writing that Leicester Spine & Wellness Center restrict how my private information is used or disclosed to carry out treatment , payment, or health care operations. I also understand that Leicester Spine & Wellness Center is not required to agree with my requested restrictions, but if they do agree then the organization is bound to abide by such restrictions.
I understand that I may revoke this consent at any time, except to the extent that Leicester Spine & Wellness Center has already taken action on this consent.

PATIENT'S NAME:_____

SIGNATURE:_____

RELATIONSHIP TO PATEINT_____

DATE:_____