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**Consent for Purposes of Treatment, Payment, Healthcare Operations**

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Summary: This consent form must be completed by a patient/guardian before the first appointment with the nutritionist (with some exceptions). In signing this consent document, the patient is permitting Christina Scribner/Encompass Nutrition LLC to use or disclose the patient’s protected health information to treat the patient, to ensure that the patient’s bills are paid, and to operate the business of the practice.

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I consent to the use or disclosure of my protected health information by Christina Scribner/Encompass Nutrition LLC for the purpose of diagnosing or providing treatment to me or my dependent child, obtaining payment for health care bills or to conduct health care operations. I understand that diagnosis or treatment by Christina Scribner/Encompass Nutrition LLC may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Christina Scribner/Encompass Nutrition LLC is not required to agree to the restrictions that I may request. However, if Christina Scribner/Encompass Nutrition LLC agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Christina Scribner/Encompass Nutrition LLC has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Christina Scribner’s/Encompass Nutrition LLC’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me, is available in the office, and describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Christina Scribner/Encompass Nutrition LLC. This Notice of Privacy Practices also describes my rights and the provider’s duties with respect to my protected health information.

Christina Scribner/Encompass Nutrition reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_

Name of Patient or Personal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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