WEST LINN AESTHETIC MEDICINE

ACKNOWLEDGEMENT AND CONSENT FOR THE NOTICE OF PRIVACY PRACTICES

I understand that West Linn Aesthetic Medicine (or referred to as "This Practice") will use and disclose health information about me, _____ **(please print full name**).

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history/status, symptoms, examinations, test results, diagnoses, cosmetic treatments/procedures, and similar types of health related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate with other health care providers for my care and treatment;
- Determine my eligibility for financial benefits and/or financial credit to Care Credit, Allergan's Brilliant Distinctions Program, other financial institutions, or others who may be responsible to pay for some or all of my cosmetic care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as the ***Notice of Privacy Practices*** and describes the uses and disclosures of health information followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the ***Notice of Privacy Practices*** may be revised from time to time, and that I am entitled to receive a copy of any revised revision. I also understand that a copy or summary of the most current version of the ***Notice of Privacy Practices*** in effect will be posted in the waiting/reception area and available on the website at www.westlinnaestheticmedicine.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the ***Notice of Privacy Practices***, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above.

_____ _____

Print Name - Patient **Date**

_____

Signature - Patient