DAYTON OUTPATIENT CENTER
Pain Management

CONSENT TO NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- For judicial & administrative proceedings according to specific requirements.

I have been informed by you of *your Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that the Notice of Privacy Practices covers all entities of Dayton Outpatient Center practices such as Pain Clinic, Ambulatory Surgery Center, Physical Therapy, Counseling, Pharmacy, Dental Clinic, Family Medicine, Occupational Medicine and any other service areas). I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Unless there is an objection we may do any of the following:

- **Call patients to confirm an appointment and may leave a message**
- **Call regarding an account (at the phone # provided by the patient)**
- **Call and/or leave a message regarding treatment/test results.**

We are only permitted to return calls left by our patients. *We will not return calls left by a spouse, family member, or friend.*

Patient Name: _____ SSN: _____

Patient Signature: _____ Date: _____

Representative Name: _____ Relationship to Patient: _____

Representative Signature: _____ Date: _____