**Release of Information**

I consent to the use or disclosure of my individually identifiable health information (IHII) by Dr. Clara Barnett for the purpose of diagnosing or providing treatment to me, obtaining payment for health care bills or to conduct health care operations of Dr. Clara Barnett. I understand that diagnosis or treatment of me by Dr. Clara Barnett may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my IHII is used or disclosed to carry out treatment, payment or health care operations of the practice. Dr. Clara Barnett is not required to agree to the restrictions I may request. However, if Dr. Clara Barnett 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 Dr. Clara Barnett has taken action in reliance on this consent.

My "IHII" 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. The IHII 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 that I have the right to review Dr. Barnett's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practice describes the use and disclosure of my IHII that will occur in my treatment, payment of bills or in the performance of health care operations of Dr. Barnett. The Notice of Privacy Practices also describes my rights and duties of Dr. Barnett with respect to my IHII. Dr. Barnett 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.

*Signature (patient or personal representative)* _____
*Date*_____

**Payment Policy**

Payment of all services rendered is due at the time of service to Dr. Clara Barnett. I have read and understood this policy.

*Signature*_____
*Date*_____

**Appointment Cancellation Policy**

I understand that 24 hours notice is required when canceling an appointment. I understand that there will be a $75 fee if less than 24 hours notice is given.

*Signature*_____
*Date*_____

Dr. Clara Barnett ND LAc