PATIENT CONSENT FORM

For Treatment, Payment, Healthcare Operations & Release of PHI

General Information: As a patient of Nancy A. Logan, PhD when you seek and receive Psychotherapy care from me, Protected Health Information (PHI) will be generated about you. This information includes your medical information (past, present and future) and personal information such as your name, address and social security number. This information will be used for the Treatment of your condition(s), obtaining Payment from your insurance company and for Healthcare operations within my office.

NOTICE OF PRIVACY PRACTICES

For a description of how your Protected Health Information may be used and disclosed, you may review our "Notice of Privacy Practices" prior to signing this consent. We reserve the right to change the notice and will notify all patients of such changes prior to the effective date.

PATIENT RIGHTS

You have the right to request a restriction of the uses and disclosures of your Protected Health Information (PHI) for the purpose of your treatment, payment for your services and the healthcare operations of our office. We are required to agree to the requested restrictions but we are bound by any restriction agreed upon

PERMISSION TO RELEASE YOUR PROTECTED HEALTH CARE INFORMATION TO FAMILY MEMBERS AND OTHERS

Please indicate below the person(s) to whom you authorize us to release medical and/or insurance information

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth

Provider has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent. In addition, the Provider is authorized by law to use and/or disclose your PHI in certain circumstances without your consent.

Your signature below acknowledges:

- You have read and understand the consent
- You agree to have the protected health information used and disclosed by the provider for the purpose of your treatment, to secure payment for your treatment, and for Providers healthcare operations
- You are permitting the release of your protected health information to the persons noted above.
- Prior to signing this consent, you given the opportunity to review the "Notice fo Privacy Practices"
- You are aware that you may now or at any time request restrictions to the use and disclosure of your protected health information

Signature of Patient or Patient's Representative _____ Date _____

Printed Name (If representative signs, include legal documentation)

Patient Date of Birth_____ Patient SS#_____