



Reflex Acknowledgement and Consent

I understand that **Reflex**, (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, 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 among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my providers efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also 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 a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices 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 Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

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.

If desired, our Reflex provider is happy to write you a 'Doctor's Note' for one day of release from work for the day of your injection. If you need additional paperwork done for Disability claims, Workers Comp, or other extended release you will need to obtain this through your primary care physician, as Reflex does not offer these services at this time.

I understand that if I need additional documentation for Disability, workers comp or other extended release I will obtain that through my primary physician.

Please see reverse side to sign



By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____
Date: _____
(Patient)

-OR-

By: _____
Date: _____
(Patient representative)

Patient has refused to sign this document: _____ Date _____
(Reflex Staff Member)

Please list anyone you authorize us to discuss your health and treatment with (such as a spouse or care giver).

Name _____ Relation _____ DOB _____

Name _____ Relation _____ DOB _____

Name _____ Relation _____ DOB _____