EXCELLHEALTH

PATIENT HIPAA ACKNOWLEDGMENT AGREEMENT

Patient Name ____ Date__________________

Address ____ D.O.B. _______________

Notice of Privacy Practices Acknowledgement

I acknowledge that I have received Excellhealth's Notice of Privacy Practices ("Notice") and understand the ways in which Excellhealth may use and disclose my Protected Health Information ("PHI") for treatment, payment, and healthcare purposes, as well as the other permitted uses and disclosures described in the Notice. I understand that I may contact the Privacy Officer designated on the Notice if I have a question or a complaint regarding the disclosure of my PHI. To the extent permitted by law, I consent to the use and disclosure of my PHI by Excellhealth for the purposes described in the Notice.

Patient Signature ____

Disclosures to Family Members and/or Friends

I give permission for Excellhealth to release my PHI for purposes of communicating results, findings, and care decisions to the family members and/or friends listed below:

Name: ____ Relationship: ____________________

Contact Information: ____

Name: ____ Relationship: ____________________

Contact Information: ____

Name: ____ Relationship: ____________________

Contact Information: ____

Consent to Email or Text Usage for Healthcare Communications

Patients may be contacted via email or text message to remind them of an appointment, to obtain feedback on your experience at Excellhealth, or to provide general health reminders/information. If at any time I provide an email or phone number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications at that email or phone number from Excellhealth. I understand that at any time I can revoke my permission to be contacted by Excellhealth via email or text message by contacting the Privacy Officer.

Patient Email and/or Phone Number: ____

Patient Signature: ____

Excellhealth does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or Excellhealth's health care operations purposes (e.g., quality improvement activities). I understand that Excellhealth retains ownership rights to the images and/or recordings. I am allowed to request access to, or copies of, the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected, and will not be used and/or released without my specific written authorization unless it is for treatment, payment, or health care operations or otherwise permitted by law.

Patient Signature: ____

Prescription Order Pick-up

Excellhealth allows a patient's friend or family member to pick up a prescription for the patient. In order to release the prescription, Excellhealth requires the designated friend or family member's name to be on file. Prior to the release of the prescription, the designee must present valid picture identification and sign for the prescription. This is an optional service and patients are not required to designate anyone to pick up prescriptions for them. A patient may revoke an authorization for a friend or family member to pick up prescriptions on the patient's behalf at any time by contacting the Privacy Officer.

I wish to designate the following friends/family members to pick up prescriptions on my behalf:

Name: ____ Date: ______________________

Name: ____ Date: ______________________

Patient Signature: ____