NICC'S **DPC**

Notice of Privacy Practices Acknowledgment Form (HIPAA)

_____(initial) I acknowledge that I have been offered or received a copy of NICC's Direct Primary Care Notice of Privacy Practices and have had an opportunity to review it. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

Consent for General Care and Treatment, Payment and Health Care Operations

I understand that, as a condition to my receiving treatment from NICC's Direct Primary Care, NICC's may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as otherwise necessary for the operations of NICC's. These uses and disclosures are more fully outlined and explained in the Notice of Privacy Practices that has been provided to and reviewed by me.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your medical provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a medical provider, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I further understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

Personally identifiable health information" refers to health and demographic information collected about me by NICC's Direct Primary Care that relates to my past, present or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time and that I have a right to obtain any revised Privacy Notice by contacting NICC's to make such a request. I also understand that I have the right to request NICC's to restrict how my health information is used or disclosed. NICC's does not have to agree to my request for the restriction, but if NICC's does agree, NICC's is bound to abide by the restriction as agreed. Finally, I understand that I have the right to revoke or withdraw this consent, in writing, at any time. My revocation or withdrawal will be effective except to the extent that NICC's has acted in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

Signature: [OBJ]	Date:

Patients Printed Name: