****

**Privacy and Sharing of Information Policy (As Required by HIPAA)**

Wax and Wane Wellness LLC - Kelly Sherman L.Ac., CHN

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented in my New Patient Intake Form. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and for any reason other than routine disclosures, such as those related to treatment, payment or health care operations will only be disclosed to third parties with my permission.

I understand that Wax and Wane Wellness LLC may need to contact me by phone or by electronic or postal mail, and that information about scheduling and payment may be contained within or attached to these communications. By providing my contact information on this form or at the time of scheduling, I give permission to this clinic to contact me to confirm scheduling and to follow up with me electronically in payment matters, including sending receipts I have requested or invoicing me when necessary. I also give my permission to this clinic to follow-up with me concerning my well-being after an appointment via phone call, text, or email and to send me any information that is a part of my treatment plan or would be beneficial for me to have as per my practitioner's judgment. I also give my permission to be added to the Wax and Wane Wellness newsletter subscription knowing that I may unsubscribe at any time.

You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Wax and Wane Wellness LLC.

You have a right to a paper copy of this Notice of Privacy Practices as well as access to the full HIPAA requirements at any time upon request.

Wax and Wane Wellness LLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Complaints about your privacy rights, or how Wax and Wane Wellness LLC has handled your health information should be directed to Kelly Sherman at (954) 729-8036. If Kelly Sherman is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:**

DHHS

Office of Civil Rights 200 Independence Avenue, S.W. Room 509F

HHH Building

Washington, DC 20201

FOR ADDITIONAL INFORMATION about extenuating circumstances when your health information may be disclosed, please visit: [www.hcfa.gov/medicaid/hipaa](http://www.hcfa.gov/medicaid/hipaa)

I have been given an opportunity to read this explanation and I acknowledge and agree to this Privacy and Sharing of Information Policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Representative\*)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient Representative\*

\* **Note:** Patient Representative should sign if patient is a minor, or otherwise unable to sign for him or herself.