**HIPAA Policy**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

The office staff has informed me of the Notice of Privacy Practices that contains a more complete description of the uses and disclosures regarding my health information. I have been given the right to review Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not

Client Signature Date

**Do No Harm Policy**

I agree to fully release and hold harmless Healing Way Center and its employees from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with

Client Signature Date

**Payment Policy**

All services are rendered on a fee for service basis. You are expected to pay for services on the

Client Signature Date

**Cancellation Policy**

If you cancel a scheduled session with less than 24 hours notice, or if you cancel a scheduled

Client Signature Date