460 Ashley Ridge Blvd, Ste 600, Shreveport, LA 71106 318.861-4226

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by White Clover Wellness & Research Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of White Clover Wellness & Research Center. I understand that diagnosis or treatment of me by White Clover Wellness & Research Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. White Clover Wellness & Research Center is not required to agree to the restrictions that I may request. However, if White Clover Wellness & Research Center agrees to a restriction that I request, the restriction is binding on White Clover Wellness & Research Center, John Reeves, MD, Bethany C. Crosby, P.A.-C and all associates.

I have the right to revoke this consent, in writing, at any time, except to the extent that White Clover Wellness & Research Center, John Reeves, MD and/or Bethany C. Crosby, P.A.-C. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review White Clover Wellness & Research Center's Notice of Privacy Practices prior to signing this document. The White Clover Wellness & Research Center Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of White Clover Wellness & Research Center. The Notice of Privacy Practices is also provided in the patient waiting area. This Notice of Privacy Practices also describes my rights and White Clover Wellness & Research Center's duties with respect to my protected health information.

White Clover Wellness & Research Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

The Health Insurance Portability Act of 1996 (HIPAA) grants you the right to designate one or more individuals to act on your behalf regarding the protection of health information that pertains to you. You may designate an individual to be your personal representative below. This person shall be given all of the privileges that would belong to you regarding your health information. Your designation can be revoked at any time by signing a revocation and delivering it to White Clover Wellness & Research Center. However, any revocation will not apply to the extent that persons authorized to use or disclose the health information have already acted in reliance on your previous designation.

_____	_____	_____
Name of Patient (please print)	Name of Designated Personal Representative	Relationship to Patient

Signature:_____ Date: _____

Print name:_____ ☐Patient ☐Parent ☐Legal Guardian/Representative:

If Applicable, Basis of representative's authority to act for patient:_____

REVOCATION SECTION: I hereby revoke my designation of a personal representative.

Signature:_____ Date: _____

Print name:_____ ☐Patient ☐Parent ☐Legal Guardian/Representative: