Consents / Signatures: *Date:* _____

I knowingly and willingly authorize the professionals at LifeArts Integrated Health Center, PC to review my past medical history, current medical history, and any pertinent data relevant to my health care. Furthermore, I acknowledge that no guarantees have been made to me concerning the results of the care and treatment, and that there are risks and benefits to any form of health care. Additionally, I acknowledge that several disciplines of health care are available at this facility, and consent to any and all forms of therapy as advised by the provider. (Any refusals are listed below) I understand that all care, including medical care provided at LifeArts Integrated Health Center, PC is performed by an Advanced Practice Registered Nurse. Having this knowledge, I knowingly authorize LifeArts Integrated Health Center, PC to proceed my care.

Signature: _____

Refused disciplines of treatment:

_____

_____

_____

PRIVACY NOTICE

The privacy notice describes how medical information about you may be used and disclosed and how you can get access to that information. We are committed to maintaining the privacy of your protected health information (PHI). This includes information about your health and the treatment that you receive. A health record is created that details the care and services you receive in this office in order to provide you with high quality health care. This notice is to inform you how your PHI may be used and disclosed to third parties. This is also to inform you of your rights regarding your PHI.

By signing below, I acknowledge that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language that I can understand.

Signature: _____

I authorize LifeArts Integrated Health Center, PC to release my PHI to the below listed individuals:

_____

_____