Artful Touch
600 1st Ave Suite 632
Seattle, WA 98104
(206) 818-6917

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Artful Touch for the purpose of treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Artful Touch.

I understand that treatment by Artful Touch may be conditioned upon my consent as evidenced by my signature on this document. I have the right to revoke this consent, in writing, at any time, except to the extent that Artful Touch has taken action in reliance on this consent.

My "protected health information" means identifiable health information, including my demographic information, collected from me and created or received by my massage practitioner, another health care provider, a health plan, my employer or a health care clearinghouse.

_____ I understand I have a right to review the Artful Touch Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. I understand that I may request an updated copy of this notice at any time.

_____ I understand that as a Licensed Massage Practitioner in the state of Washington, Artful Touch is not able to provide any diagnoses to me regarding my state of health. I understand that my massage practitioner does not replace my medical doctor, and under certain circumstances my treatment may be conditioned upon diagnosis from a doctor.

_____ I agree to pay the rate of $80 per hour for my treatment with Artful Touch no later than the time of service by cash, check, or paypal. Session activities may include manual therapies, intake, postural observation, as well as table massage.

_____ I understand the cancellation policy of Artful Touch and agree to pay $40 for any session in which I do not show, or in which I fail to provide more than 48 hours notice of cancellation. I understand that I may not be charged this fee if my session can be otherwise filled.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

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NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Artful Touch uses health information about you for treatment, to obtain payment for treatment (with your authorization as required per state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Artful Touch will not disclose your identifiable information to others unless you tell us to do so or unless the law requires and authorizes us to do so.

Artful Touch may use your information to distribute mailings (e.g. appointment reminders) and to provide information about treatment alternatives or other health-related issues.

You may complain to the business owner, Courtnee Papastathis, and to the Department of Health and Human Services if you believe your privacy rights have been violated. There will be no retaliation made against you for filing a complaint.

Artful Touch must maintain the privacy of protected health information; provide you with notice of its legal duties and privacy practices with respect to your health information; abide by the terms of the notice, notifying you if unable to agree to the requested restriction on how your information is used or disclosed; accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations; and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or comments, please contact Courtnee Papastathis at (206) 818-6917.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority