LOIS THOMSON BOWERSOCK & associates, llc

1733 Woodstead Ct. Suite 101, The Woodlands, TX 77380
Phone: (281) 419-5255 Fax: (281) 419-5251
E-Mail: lois@loisbowersock.com Web: www.loisbowersock.com

HIPAA – Review of Privacy Notice Acknowledgement

Effective April 14, 2003, Revised January 1, 2018

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. This Notice contains a Client's rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. Due to HIPAA, the following information must be updated by each Client annually.

I the Client understand that:

- Protected Health Information (PHI) may be disclosed or used for treatment, payment, or other healthcare operations.
- Lois Thomson Bowersock & Associates, LLC has a Notice of Privacy Practices and the Client has the opportunity to review the Notice.
- The Client can view and download the Privacy Practices of Lois Thomson Bowersock & Associates, LLC at: www.loisbowersock.com
- Lois Thomson Bowersock & Associates, LLC has the right to change the Notice of Privacy Policies.
- The Client has the right to restrict the uses of their information but Lois Thomson Bowersock & Associates, LLC does not have to agree to those restrictions.
- The Client may revoke this consent at any time and all future disclosures will then cease.
- Lois Thomson Bowersock & Associates, LLC may condition treatment upon the execution of this consent.

By signing I hereby authorize Lois Thomson Bowersock & Associates, LLC to release my Protected Health Information (PHI) or insurance information as necessary to process my medical claims and coordinate or manage my mental health care.

_____ _____

Signature of Client or Legal Representative Printed Name of Client or Legal Representative

_____ _____

Witnessed Date

HIPAA – Review of Privacy Notice Acknowledgement

I have reviewed the Notice of Privacy Practices of Lois Thomson Bowersock & Associates, LLC, which explains how my Protected Health Information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Persons authorized to receive my Protected Health Information:

1._____
Name Contact Information - Telephone / E-mail/ Fax

2._____
Name Contact Information - Telephone / E-mail/ Fax

3._____
Name Contact Information - Telephone / E-mail/ Fax

To authorize Lois Thomson Bowersock & Associates, LLC to communicate with you via the methods indicated, sign your initials beside "Yes".

Note: Federal law restricts our ability to communicate with you without your consent.

Yes ____ No ____ **I consent to be contacted by e-mail.**

_____
Email address - please print clearly

Yes ____ No ____ **I consent to be contacted by mail via US postal service.**

_____
Street Address Apt #

_____
City Zip State

Yes ____ No ____ **I consent to be contacted at the following telephone numbers:**

_____ _____
Cell Home

_____ _____
Work Fax

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To communicate with you via telephone messages, initial beside all that you consent to:

Yes ____ No ____ It is okay to leave specific messages with personal details.

Yes ____ No ____ It is only okay to leave a general message without personal details.

Yes ____ No ____ Do not leave any messages at all.

Yes ____ No ____ It is okay to send specific text messages with personal details.

Yes ____ No ____ It is okay to send a general text message, without personal details.

Yes ____ No ____ Do not send any text messages

Note: Federal law restricts our ability to communicate with you without your consent.

_____ _____

Signature of Client / Parent if minor Relationship to Client

_____ _____

Printed Name of Client Printed Name of Parent if Minor

_____

Date

Changes to this document must be submitted in writing. This form is in compliance with HIPAA guidelines. A copy of these guidelines is available upon request or maybe obtained at www.loisbowersock.com