Acknowledgement and Consent of Notice of Privacy Policy

I understand that Waverly Psychiatry, LLC (referred to as 'This Practice" listed below) will use and disclose health information about me. I understand that my health information may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

Make decisions about and plan for my or my child's care and treatment; refer to, consult with, coordinate among, and manage along with other health care providers for my or my child's care and treatment.

Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.

Perform various office, administrative, and business functions that support my doctor's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Policy and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Policy may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Policy. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Policy in effect will be posted on This Practice's website, https://www.waverlypsychiatry.com

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Policy, and I understand that This Practice is not required by law to agree to such request.

By signing below, I agree that I have received and understand the information above and that I have reviewed the Notice of Privacy Policy.

Signature:_____

Name: _____
(Patient)

Date:_____

OR

Signature:_____

Name: _____
(Patient Representative)

Date:_____

Relationship with the patient:_____