



SC Professional Services, LLC
DBA Hope Integrative Medicine
1064 Gardner Road, Suite 215
Charleston, SC 29407
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HIPAA Patient Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third-party payers and insurance companies.
- Conduct normal healthcare operations such as quality assessment and provider certifications.

I have been given a copy of the Notice of Privacy Practices by Hope Integrative Medicine and have been given the opportunity to read this notice before signing this consent. I understand that Hope Integrative Medicine has the right to change its Notice of Privacy Practices from time to time and that I may contact this facility at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Hope Integrative Medicine is not required to agree to my requested restrictions, but if it does agree, then it is required to abide by these restrictions.

I understand that I have the right to revoke this consent in writing at any time. I understand that revocation of this consent will not affect any action taken by Hope Integrative Medicine in reliance on this consent before its revocation. I understand that Hope Integrative Medicine may decline to treat me or continue to treat me if this consent is revoked.

Printed Name – Patient or Responsible Party

Date of Birth

Patient Signature or Responsible Party

Date