Kenneth Gates and Associates
8600 Route 14, Suite 110
Crystal Lake, IL 60012

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations, Including Confidentiality and Its Limits

I ____ understand that as part of my health care. Kenneth Gates and Associates originates and maintains paper and/or electronic records describing my health history, symptoms, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I can request a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Kenneth Gates and Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse to treat me.

I understand that I have the right to have information disclosed in the context of therapy held in the strictest of confidence and that information will not be shared outside the practice without my written consent. I also understand that there are limits to the Practice's legal obligation to hold that information in confidence. In cases where my therapist believes there is significant risk of harm to myself or others, or in cases in which my therapist believes abuse has taken place or is taking place to a child or an elderly person; my therapist may have an obligation to report such instances to the authorities. I also understand that, for the purpose of providing the best possible care, my therapist may consult with his or her colleagues within the practice regarding my case unless I request a restriction to that consultation.

☐ I wish to have the following restrictions to the use or disclosure of my health information:

☐ I fully understand and accept the terms of this consent.

Client's Signature: ____Date: _______________