

**ACKNOWLEDGMENT AND CONSENT**

**I understand that Terrel L. Templeman, Ph.D.** will use and disclose certain health information about me to process insurance forms. This information may be in the form of written or electronic records, oral communications, and will include my health status, symptoms, test results, diagnoses, treatment plans, prescriptions, and similar types of health-related information which have been designated Protected Health Information according to the Health Insurance Portability and Accountability Act of 1996. By signing this authorization I consent to **Dr. Templeman** providing Protected Health Information to my insurance company for payment of my bill and auditing his treatment of me, using this information to consult with my personal physician and other health care providers, and office staff involved with my scheduling and billing.

I understand that Protected Health Information about me is distinct and separate from **Dr. Templeman’s** psychotherapy notes, which document session by session issues discussed in therapy between us. Such issues are considered privileged and require separate consent by me to disclose to anyone else, subject to conditions listed in the Notice of Privacy Practices, which I have read.

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

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of my provider’s Notice of Privacy Practices in effect will be posted in the waiting/reception area.

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 Practices, and I understand that my provider is not required by law to agree to such requests.

**By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

**OR**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient’s Representative)

Description of Representative’s Authority: \_\_\_\_\_