APEX
MEN'S HEALTH CLINIC

NOTICE OF PRIVACY PRACTICES & GENERAL CONSENT FOR CARE

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

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, including quality assessments and physician certifications.

I have received, read, and understand the Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I acknowledge that this organization may change its Notice of Privacy Practices, and I can contact this organization at any time to obtain a current copy.

I may request in writing that restrictions be placed on how my private information is used or disclosed for treatment, payment, or healthcare operations. I understand that the organization is not required to agree but, if agreed, will abide by such restrictions.

Consent for Care and Treatment:

As a patient, I have the right to be informed about my condition and recommended surgical, medical, or diagnostic procedures. This consent authorizes reasonable and necessary medical examinations, testing, and treatment. I acknowledge that this consent is continuing, even after a specific diagnosis and treatment recommendation.

I voluntarily request healthcare providers to perform reasonable and necessary medical examinations, testing, and treatment. If additional testing or procedures are recommended, I may be asked to sign additional consent forms.

I have the right to discontinue services at any time and discuss the treatment plan, including potential risks and benefits. If I have concerns, I am encouraged to ask questions.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

Print Name:_____ Date:_____

Patient Signature:_____