# 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.

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 and have been provided with 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 further understand that Kenneth Gates and Associates reserves the right to change their notice and practices. Prior to implementation Kenneth Gates and Associates will send a copy of the revised notice to the address I have provided.

☐ 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: _____