

**ELAINE CHU, MD**  
**EAST-WEST INTEGRATIVE MEDICINE**  
3527 Ocean View Blvd  
Glendale CA 91208

**Patient Consent for Medical Care and Assignment of Benefits**  
**Patient Consent for Use and Disclosure of Protected Health Information**  
**Written Acknowledgment of Receipt of Notice of Privacy Practices**

I authorize **ELAINE CHU, MD** to provide me, \_\_\_\_\_ with medical services.

**Payment Assignment.**

I authorize my insurance benefits be paid directly to **Elaine Chu, MD** or **Elainemd, inc.** I agree to pay any required co-payments at the time of service. I also understand that I am responsible for services not paid by insurance.

**Communication.**

**Elaine Chu, MD** may *call* my home or other alternative location and *leave a message* on voice mail or in person for items of treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and clinical care, including test results.

**Elaine Chu, MD** may *mail* to my home or other alternative location items for treatment, payment, and healthcare operations, such as appointment reminder cards, financial statements, and clinical care items, including test results. Clinical information will be marked Personal and Confidential.

**Elaine Chu, MD** may *e-mail* to me items in reference to treatment, payment, and healthcare operations, such as appointment reminders and announcements. Clinical information will be offered through *unsecured email* using this email address \_\_\_\_\_

**I understand that e-mail is never appropriate for urgent or emergency situations.**

**Privacy Practices.**

I acknowledge receiving the Notice of Privacy Practices. I have the right to review this Notice prior to signing this consent and to obtain a copy at any time. This Notice can be revised at any time.

As outlined in the Notice of Privacy Practices, I authorize **Elaine Chu, MD** to use and release my protected health information for treatment, payments, and healthcare operations.

I have the right to request that **Elaine Chu, MD** restrict the use or disclosure of my protected health information. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Elaine Chu, MD** may decline to provide treatment to me.

I specifically authorize **Elaine Chu, MD** to communicate issues of my health and medical care with the following persons (Please list contact information): \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Print Name of Legal Guardian

\_\_\_\_\_  
Relationship to Patient