

ACKNOWLEDGEMENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

My PHI (“Protected Health Information”) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or is a reasonable basis to believe the information may identify me.

I understand that diagnosis or treatment of me by ADVANCED PHYSICAL & SPORTS THERAPY may be conditioned upon my consent as evidenced by my signature on this document.

RELEASE OF INFORMATION

I hereby authorize the use and disclosure of my PHI by telephone or in writing. This may including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by ADVANCED PHYSICAL & SPORTS THERAPY to the physician who referred me for therapy, as well as any organization responsible for payment of my account. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

I understand I have the right to revoke this consent, in writing, at any time, except to the extent that **Douglas T. Heckenkamp, M.P.T. or ADVANCED PHYSICAL & SPORTS THERAPY** has taken in reliance on this consent.

I understand that I have the right to review ADVANCED PHYSICAL & SPORTS THERAPY’S **Notice of Privacy Practices** prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that may occur in my treatment, payment of my bills or in the performance of healthcare operations of the facility. This notice may be made available to me upon my request.

ADVANCED PHYSICAL & SPORTS THERAPY reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for a copy at my next appointment.

In order for our therapists to provide top quality care we are unable to allow children to accompany their parents to their appointments. We will not under any circumstances allow children to remain in the waiting area without adult supervision.

CONSENT FOR TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of **ADVANCED PHYSICAL & SPORTS THERAPY**.

Patient Signature

Date

Signature of Parent or Legal Guardian of Minor Patient

Relationship to Patient

Please Initial Appropriate Response:

_____ I have reviewed a copy of Advanced Physical & Sports Therapy’s Privacy Practices

_____ I have received a copy of Advanced Physical & Sports Therapy’s Privacy Practices

_____ I decline to receive or review a copy of Advanced Physical & Sports Therapy’s Privacy Practice