PATIENT CONSENT FORM

PATIENT CONSENT FOR EVALUATION & TREATMENT

☑ I understand that the physical therapist will explain to me any potential risks, benefits and alternatives of treatment. I understand that there are no guarantees regarding cure or improvement in my condition. I understand that my physical therapist will outline and discuss the goals of physical therapy for my condition and review treatment options with me. I do hereby consent to such treatment by the authorized personnel of Physical Therapy Partners, Inc. as may be dictated by prudent medical practice for my illness, injury, or condition. This is intended as a waiver of liability for such treatment excepting acts of negligence.

NOTICE OF PRIVACY PRACTICES (HIPAA) Consent For Use And Disclosure of Protected Information

☑ I understand that Physical Therapy Partners, Inc. will maintain confidential information about me in the course of providing my medical care and treatment and that such information is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I consent to the use and disclosure of such information by Physical Therapy Partners, Inc. for medical treatment and payment. I have been given the opportunity to review the Notice of Privacy Practices that further explains the use and disclosure of protected information which is available in print in the offices of Physical Therapy Partners, Inc. and also on the website www.physicaltherapypartnersinc.com. I understand that the Privacy Practices may change in the future and revisions may be obtained at the offices of Physical Therapy Partners, Inc. I understand that I may request restrictions on the use or disclosure of this information although Physical Therapy Partners, Inc. is not required to agree to such a request. I understand that I may revoke my consent in writing but that any revocation does not affect use or disclosure that has already occurred.

☑ I grant permission to disclose information related to my physical therapy medical status and/or billing account to the following individual/s:

_____ _____ _____

Name *Relationship* *Phone Number*

AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

☑ I acknowledge that I have been notified that Physical Therapy Partners, Inc. routinely attempts to contact patients during normal business hours and is occasionally unable to reach patients directly during that time. On these occasions clinic staff leaves messages on answering machines or voice mail at numbers provided by the patient. Information that may be disclosed on a home, work, or cell phone could include, but is not limited to, scheduling concerns or appointment information. I also understand that I may elect to receive appointment reminder notifications via text message and/or email. If elected, I understand that any charges I incur from my third party vendors for the delivery of such messages are my sole responsibility.

☐ I **DO** wish to receive text reminders of scheduled appointments on my cell phone.
☐ I **DO** wish to receive email reminders of scheduled appointments.

Cell : _____ Home: _____ Work: _____
Messages OK: YES / NO YES / NO YES / NO

Email Address (print CLEARLY): _____

_____ _____
Patient or Authorized Signature Date Signed

_____ _____
Witness Date Signed

O$:/Forms for Charts/NP Forms Current Versions/Consent Form Ltrhd 2016