PATIENT CONSENT FORM

PATIENT NAME: _____

DOB: _____

PATIENT CONSENT FOR EVALUATION & TREATMENT

❑ I understand my physical therapist will explain to me any potential risks, benefits and alternatives of treatment, discuss the goals of physical therapy for my condition and review treatment options with me. I understand that there are no guarantees regarding cure or improvement for my condition. I consent to 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 keep my medical information private as required by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the use and sharing of my information for medical care and payment. I have received a copy of the Notice of Privacy Practices, which explains how my information is used and shared. This notice is available at the office and online at www.physicaltherapypartnersinc.com. I understand that the Privacy Practices may change, and I can request updated copies. I may ask for limits on how my information is used or shared, though Physical Therapy Partners, Inc. may not always agree. I can revoke my consent in writing, but this will not affect any prior use or sharing of my information.

❑ I grant permission to disclose information related to my physical therapy medical status to the following:

_____	_____	_____
Name	*Relationship*	*Phone Number*

AUTHORIZATION FOR USE OF VOICE MAIL / Leave a message

❑ I understand that Physical Therapy Partners, Inc. may leave messages with scheduling or appointment details on my voicemail or answering machine if I cannot be reached during business hours. Messages will only be left at the phone numbers I have provided. I may also choose to receive appointment reminders by text or email. I am responsible for any fees from my service provider for these messages.

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

☐ I **DO** wish to receive text reminders of scheduled appointments
☐ I **DO** wish to receive email reminders of scheduled appointments

Email Address (print CLEARLY): _____

_____ _____
Patient Signature Date Signed

_____ _____
Physical Therapist Date Signed