HIPAA Compliance – Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations, the practice reserves the right to change the privacy policy as allowed by law, the practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions, the patient has the right to revoke this consent in writing at any time and all full disclosures will then cease, the practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments to be used so that you may make the decision whether to undergo any suggested treatment after being informed of the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is an effort to obtain your permission to perform the evaluation necessary to choose the appropriate treatment(s) for any identified condition(s).

This consent provides us with your permission to perform a reasonable and necessary medical examination, testing, and treatment. By signing below, you indicate that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made with recommended treatment(s); and (2) that you consent to treatment at this office. This content will remain fully effective until it is revoked by you in writing. You have the right at anytime to discontinue our services.
You have the right to discuss the treatment plan with your physical therapist about the purpose, potential risks, and benefits. If you have any concerns regarding the evaluation, tests, or treatments recommended by your physical therapist, we encourage you to ask questions.

By signing below, I certify that I have read and fully understood the above statements and consent fully and voluntarily to its contents.

Date: _______________ Patient Name: ___________________________________

Patient Signature:_______________________________