Siesta Key Physical Therapy, LLC

Consent and Privacy Notice

CONSENT TO TREATMENT: I consent to rehabilitation and related services at SIESTA KEY PHYSICAL THERAPY. I understand that it is my right to accept or decline any services offered to me. I acknowledge that no guarantee has been made as to the results that may be obtained from such treatments. I understand that such services may involve direct contact of a sensitive nature ***_____(initials)**

AUTHORIZATION OF PAYMENT: I request that payment of the Medicare/Insurance benefits be made on my behalf to SIESTA KEY PHYSICAL THERAPY for any services rendered to me by SIESTA KEY PHYSICAL THERAPY. I hereby assign all benefits directly to SIESTA KEY PHYSICAL THERAPY and also authorize release of any medical records necessary to facilitate my treatment or process medical claims and otherwise permitted in the Notice of Privacy Practices. SIESTA KEY PT or MBA may verify insurance benefits on my behalf. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance, and all amounts identified by the insurer as the patient's responsibility. I understand that in the event that my insurance company or financially responsible party does not pay for the services I receive, I will be responsible for payment *** _____ (initials)**

WAIVER AND RELEASE: I hereby release, discharge, and acquit SIESTA KEY PHYSICAL THERAPY, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including by not limited to ambulance, EMT, physician, or urgent care services. ***_____ (initials)**

LIABILITY: I know and agree that SIESTA KEY PHYSICAL THERAPY is not responsible for loss or damage to personal items.

***_____ (initials)**

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim I may have resulting from failure to do so.

***_____ (initials)**

NOTICE OF PRIVACY PRACTICES: The Healthcare Insurance Portability and Accountability Act of 1996 ("HIPPA") is a federal program, which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for our visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

Patient/Guardian Signature: _____ Date _____ *Please initial above*

Witness Signature: _____