Holistic Physical Therapy and Wellness - 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. NOTE: This is not a medical records release for physical therapy records, you must sign a separate Medical Release form to obtain records from our office.
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.

Consent for Treatment:
I hereby consent to receive care for therapy services by Holistic Physical Therapy and Wellness. I consent to therapy treatment as is deemed necessary or advisable by the therapist(s) and therapy support staff. In consideration for my participation in any services offered by Holistic Physical Therapy and Wellness and its contract practitioners, I do assume all risk and agree to hold Amy Koch, PT and contract practitioners harmless from any and all liability, actions, claims, demands of every kind and nature whatsoever which may arise.

Consent to Release Medical Information:
I authorize Holistic Physical Therapy and Wellness to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and ____________________

Consent to Obtain Medical Information:
I authorize Holistic Physical Therapy and Wellness to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

Assignment of Insurance Benefits:
I hereby authorize payment to be made directly to Amy Koch, PT.

Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered or when billed. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

I agree to give 24 hours advance notice to cancel any appointments or pay a late cancel/no show fee.
I hereby certify that I understand these rights as set forth.

Patient/Responsible Party
Signature:____Date:_________________________

May we email or send a text to you to confirm appointments? YES______ NO _______
May we leave a message on your answering machine or on your cell phone? YES______ NO _______