

Holistic Physical Therapy and Wellness - HIPAA Compliance/Patient Consent Form

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
 - File a complaint with your provider or health insurer, or
 - File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Your health information cannot be used or shared without your written permission unless this law allows it.

Consent for Treatment: I hereby consent to receive care for therapy services by Holistic Physical Therapy and Wellness and contracted providers. 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 Mara, PT and all 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 and clinical records to myself, my insurance(s), and physician's office.

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 Holistic Physical Therapy & Wellness/ Amy Mara, 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 of \$100.

I hereby certify that I understand these rights as set forth.

Please sign below:

Patient Signature / Responsible Party: _____

Date: _____

May we leave a voicemail? YES NO May we text your cellphone? YES NO