Patient Name: _____

Consents, Authorizations, and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html**.**

1. **The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.**

2. **The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.**

3. **The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care of services.**

4. **This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.**

5. **Patients have the right to file a formal complaint with our privacy official about any suspected violations.**

6. **This office has the right to refuse treatment if the patient does not accept the terms of this policy.**

Initial: _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by attending physician or practitioner. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial: _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no know limitations that would forbid the taking of x-ray.

The patient further agrees that this office may seek outside interpretation of patient x-rays to a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial: _____

Assignment of Benefits and Financial Agreement

The patient hereby assigns benefits to be paid directly to this provider by all of their third-party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. In the event of insurance benefits paid to myself I agree to endorse said insurance payment to Aries Physical Therapy. I understand I am responsible to Aries Physical Therapy for all or any part of the charges incurred at the time of service or for any service not covered by my insurance carrier.

Initial: _____

Release of Records

The patient authorizes this office to release any information required by a third-party payor necessary for reimbursement of charges incurred.

Initial: _____

Patient Signature: _____ Date: _____