25865 W. 12 Mile Rd
STE# 104 Southfield
M.I. 48034
Phone # (248) 208-7492
Fax # (248) 208-7494

Patient Consent Form

I hereby authorize Mi Therapy Clinic and any of their contractors (collectively referred to as Provider) to render Patient Physical/Occupational/Speech services that Provider and Patient's Physician determine to be necessary. I hereby assign and transfer to provider the right to any and all payments (Medicare, Medicaid and or Private Insurance benefits) that are entitled for therapy services rendered to the patient by the Provider. I also authorize provider to apply and file for all such benefits for therapy services.

I authorize Provider to disclose or discuss any information related to therapy services to physician, insurance company, family members, and government agency upon request by them. I understand it is my responsibility to know my insurance coverage for therapy. I understand that I will be responsible for any portion of payment that is not paid except for payments denied by Medicare or any other Insurance carrier Secondary to non-medical reasons.

I hereby certify that all information provided to the Provider is true and accurate.

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from 3rd party payers.
3. Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may request the same if needed by writing to the address above.

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

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Patient Signature or Legal Representative **Date**