Consent to Physical Therapy Evaluation and Treatment.

I hereby consent to the evaluation and treatment of my condition by a licensed Physical Therapist employed by Sifrit Sports Rehabilitation. The Physical Therapist will explain the nature and purpose of these procedures, evaluation, and course of treatment. The Physical Therapist will inform me of expected benefits and complications, and any discomfort, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment. Assignment of Benefits and Insurance Proceeds I authorize payment of medical benefits to Sifrit Sports Rehabilitation for services rendered. Sifrit Sports Rehabilitation will make reasonable efforts to collect insurance proceeds by completing insurance forms and sending forms to the insurance company. Completion of such forms and/or the acceptance of the assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy. **Patient Information Consent Form (HIPAA)** I have read and fully understand Sifrit Sports Rehabilitation's notice of information practices. I understand that Sifrit Sports Rehabilitation may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Sifrit Sports Rehabilitation will consider requests for restrictions on a case basis, but is not required to oblige to such requests. I hereby consent to the use and disclosure of my personal health information for purposes as noted in this consent by notifying the practice in writing at any time, at which point Sifrit Sports Rehabilitation has 30 days to respond to my request. Release of Information I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original. **Designated Individuals Authorization**: **I, _____,** hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. **If none, please print "NONE" below**. Authorized Designee:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I have read and understood the above consents, assignment of benefits, release of information, and designated individuals authorization above.

Patient Signature:_____ Date:_____