PATIENT AUTHORIZATON FORM

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Informed Consent and Release of Information

I understand that as a patient of Physical Therapy Specialists of Winchester (PTSW):

* I have the right to receive complete and current information concerning my diagnosis, treatment, and any known prognosis. This information will be communicated to me by my therapist in terms I can understand.
* I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment. I understand that if I refuse recommended treatment, PTSW has the right to discharge me from therapy.
* Patient rights will be posted in a prominent location for my review and I can discuss any questions with my therapist.
* I understand that rehabilitative care may involve bodily contact, touching and /or direct contact as a part or an evaluative, assessment, and/or treatment process.
* I give PTSW permission to release information verbal and/or written contained within my medical record to my insurance company, case manager, attorney, employer, and healthcare practitioner as they relate to my treatment or payment of treatment.
* I give PTSWE permission to obtain medical records and health information from my physician or other medical professional as it related to my treatment.

ASSIGNMENT OF BENEFITS

I authorize payment directly to PTSW for services and to bill and release payment directly to PTSW for any physical therapy services provided. I hereby assign all benefits directly to PTSW and authorize release of any medical records necessary to process medial claims forms. *I understand that in the event my insurance company or financially responsible party does not pay for the services, I will be financially responsible for payment.*

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT)

I acknowledge that I have received a copy of the Notice of Privacy Practices for PTSW. I consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations.

PATIENT INFORMATION SHEET

I acknowledge that the information provided on the patient intake form is correct to the best of my knowledge.

Patient/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_