Patient Information

Full Legal Name: Date of Birth:

Nickname/How you like to be addressed: Gender:

Physical Address:

Mailing Address:

Employer: Work Phone:

Occupation/ Employment Status:

Home Phone: Cell Phone:

Email Address:

Please circle the best way to reach you: Home Phone / Work Phone / Cell Phone/ Email

Responsible Party (person who should receive the bill)- If different than the above

Name: Date of Birth:

Address:

Relationship: Phone:

Emergency Contact

Name Relationship

Phone:

Consent to Treat

I authorize the provider in charge of the care of the patient listed below, to provide diagnosis and treatment of services while a patient at Connect Movement Center LLC. I authorize the release of any medical information necessary to process payment for services rendered.

Signature: ____ Date: __________________

Printed Patient Name:____

Release of Information and HIPAA Privacy Notice:

I authorize any physician, hospital, school, referring agency or other person who has records pertaining to treatment at Connect Movement Center LLC to release such records, upon request, to our facility. Furthermore, I authorize Connect Movement Center LLC to use or release any of my records it may have to third party payors, government agencies, healthcare providers or other organizations that may assist them in meeting my healthcare needs. I may revoke this authorization in writing at any time and that such revocation will be effective as of the date the written revocation is received by Connect Movement Center LLC.

Privacy Notices: You, the below named patient, are entitled to certain privacy rights regarding protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). During the course of treatment, we collect paper and/or electronic records describing your health history, symptoms upon examinations and test results, diagnoses, treatment and any plans for future care or treatment. You understand that this information serves as:

- A basis for planning my care and treatment
- A means by which third party payors can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

You have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of your health information for directory purposes
- The right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment or health care operations.

We treat this information as confidential and realize the importance of protecting that information. A complete copy of our HIPAA Privacy Practices is available upon request.

By signing below, I am acknowledging I have read the above information and fully understand and accept the terms of this consent.

Signature: ____ Date_________________

Printed Name: ____