C.H.O.O.S.E Physical Therapy, LLC

Patient Notice of Privacy Practices and Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, C.H.O.O.S.E Physical Therapy, LLC, originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatments and plans for future care or treatment. This notice describes how medical information about you may be disclosed. *Please read it carefully.*

C.H.O.O.S.E Physical Therapy, LLC., will use your information for the following purposes:

1. A basis for planning my care and treatment, including providing medical records and consulting referring physicians and other healthcare professionals involved in my treatment.
2. For obtaining payment by applying diagnoses and physical therapy information to my bill and to file any necessary insurance claims to insurance companies, attorneys, or collection agencies to obtain payment for my services. A means by which third party payers can verify that services billed were accurately provided.
3. A tool for routine healthcare operations such as assessing the quality and reviewing the competence of healthcare professionals.

****I understand that I may review a more complete description of the information uses and disclosure that is posted and the I have the right to review this information prior to signing the consent form. ****

Questions *Must* be completed:

Name of person(s) we may speak to regarding your health (to include spouse, child, family members/friends):

a._____ c._____

b._____ d._____

Name of any other physicians, healthcare professionals, or attorneys involved with your care:

a._____ d._____

b._____ e._____

c._____ f._____

Emergency Contacts (*not living with you*):

Name:_____ Phone #:_____

Address:_____

Patient Name:_____ Patient Signature:_____ Date:____

Guardian Name:_____ Guardian Signature:_____ Date:____