



Achieve Orthopedic Rehab Institute
Private Owned and Independent Physical Therapy Center



**Consent for Release and Use of Confidential Information and Receipt of
Notice of Privacy Practices Form**

I, _____, hereby give my consent to Achieve Orthopedic
Name of Patient or Authorized Agent

Rehab Institute to use or disclose, for the purpose of carrying out treatment,
payment, or health care operations, all information contained in the patient
record of _____.
(Patient's Name)

I acknowledge receipt of the physical therapist's Notice of Privacy Practices.
The Notice of Privacy Practice provides detailed information about how the
practice may use and disclose my confidential information.

I understand that the physical therapist has reserved a right to change his
or her privacy practices that are described in the Notice. I also understand that a
copy of any Revised Notice will be provided to me or made at the office visit.

I understand that this consent is valid until it is revoked by me. I
understand that I may revoke this consent at any time by giving written notice of
my desire to do so, to the physical therapist. I also understand that I will not be
able to revoke this consent in cases where the physical therapist has already
relied on it to use or disclose my health information. Written revocation of
consent must be sent to the physical therapist's office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient
_____.

- Patient's file



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RECEIPT OF NOTICE OF PRIVACY PRACTICES
FORM

I, _____, hereby acknowledge receipt
(Patient's Name)

of the physical therapist's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physical therapist has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient
_____.

– Patient's file



Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this Achieve Orthopedic Rehab Institute office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this Achieve Orthopedic Rehab Institute office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Achieve Orthopedic Rehab Institute Physical Therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

/ /
Date



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CONSENT/AUTHORIZATION FORM

Physical Therapist(s):

- Ashraf Abdelhamid, PT, MS, OCS
Robert Johnson, PT, MS, OCS
Jacie Kuchan, PT, DPT, CLT
Philip A. Kushner, DPT
Anita Galco, DPT, ATC
Katarzyna Sacha, PT, OMPT
Young Jee Filer, PT, MPT
Phillip Sparacino, PT, DPT, OCS
Unsoo Kim, PT
Dave McCartney, PT, MS, AT/L
Paula Johnson, PT, MOMT
Frank DiLiberto, PT, MS, OCS, CSCS

CONSENT FOR TREATMENT: I authorize the above-named physical therapist(s), to perform the treatment procedure(s) described below. I have been informed of the reasons for the treatment/procedures along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following:

- Therapeutic Exercises
Pain treatment Modalities (Interferential- Ultra sound- Ice or Heat)
Manual therapy
Others:

The treatment/procedure(s) was explained to me in detail and all my questions were fully answered. Understanding this, I authorize the above-named physical therapist(s) to perform such examinations, treatments, laboratory tests, and to administer such medications as in his or her opinion, are necessary or advisable for me

(or Name of patient).

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RELEASE OF MEDICAL RECORD: In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider if any who referred me here.

INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to the above-named doctor(s) on my behalf for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governments private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all my charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original.

Signed: Date: