PERFORMANCE PHYSICAL THERAPY

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Patient Information Consent Form

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 KSR Performance Physical Therapy, LLC. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Access to and Release of Health Information (HIPAA):

I understand that KSR Performance Physical Therapy may document medical and other information related to my treatment in electronic and other forms and that such information will be used 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 authorize my clinician(s) and KSR Performance PT's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received, read (or had the opportunity to read) and fully understand KSR Performance Physical Therapy's Notice of Privacy Practices (on www.ksrpt.com) and that it outlines how my health information may be used and disclosed and how I gain access to and control my health information. I was given a copy of the Notice for my records (digitally or hard-copy) if I so requested.

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 release of any information. If none, please print "none" below.

Authorized Designees:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I have read and understand the above consents, release of information, and designated individuals authorization above.

Patient Signature _____ Date _____