

New Patient Consent to the use and Disclosure of Health Information for Treatment, Payment or Healthcare Options (HIPAA)

I, _____ understand that as part of my healthcare, Physio Pro PC originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand this information serves as:

- ❖ A basis for planning my care and treatment
- ❖ A means by which a third party payer can verify that service billed was actually provided and
- ❖ A tool for routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices which provides a more complete description of information uses and disclosures. I understand I have the following rights and Privileges:

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

I understand that Physio Pro PC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the code of Federal Regulations.

I further understand that Physio Pro PC reserves the right to change their notice and practices prior to implementation, in accordance with section 164.506 of the Code of Federal Regulations. Should Physio Pro PC change their notice they will send a copy or any revised notice to the address I've provided (whether US Mails, or, if I agree, e-mail)

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of my treatment, payment or healthcare options, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

Continued on Back:

I fully understand the HIPAA regulations and disclosures and ACCEPT or DECLINE the terms of this consent.

Patients Signature

Date

FOR OFFICE USE ONLY

Consent Received by: _____

Consent Refused and treatment refused as permitted: _____

Consent to the patients medical record on: _____