Bodies in Balance Physical Therapy

RELEASE OF INFORMATION & FINANCIAL RESPONSIBILITY:

I hereby acknowledge my responsibility for full payment of this debt for service of concussion baseline screening.

INITIAL HERE:_____

ACKNOWLEDGEMENT OF HIPAA REQUIREMENTS:

I have read and fully understand Bodies in Balance Notice of Information Practices. I understand **HIPAA** requirements and that Bodies in Balance may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation for the quality of services provided & any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used & disclosed for treatment, payment & administrative operation if I notify the practice. I herby acknowledge to the use and disclosure of my personal health information for the purposes as noted in Bodies in Balance Physical Therapy's Notice of Information practices, I understand and retain the right to revoke this acknowledgement by notifying the practice in a writing at any time.

INITIAL HERE:_____

DESIGNATED INDIVIDUALS AUTHORIZATION:

I herby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment. I understand that the identity of these designated parties must be verified.

Parent/Guardian :_____
Physician:_____
Other (i.e.: spouse, family member):_____

CONSENT TO TREAT & INFORMATION ACKNOWLEDGEMENT:

I, the undersigned, do hereby agree and give my consent for Bodies in Balance Physical Therapy to furnish medical care & treatment to _____ (Patient's Name), considered necessary and proper in diagnosing or treating his / her physical condition.

_____ _____ _____
Parent/Guardian Name Signature of Parent/Guardian Date

(required if under age 18)