Consent for Treatment/Privacy Notice

I hereby authorize Advanced Care Physical Therapy to provide professional services to include physical therapy or other services which my physician may prescribe. I understand all services are provided at the direction of and in consultation with a licensed physician. I further understand I may choose to terminate these services by notifying my physician and/or Advanced Care Physical Therapy.

I hereby authorize Advanced Care Physical Therapy and all healthcare providers furnishing within Advanced Care Physical Therapy's facilities to use and disclose my protected health information for the purposes of treatment, payment, and health care operations including procurement of necessary treatment equipment.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to Advanced Care Physical Therapy. This may be delivered in person or by mail, but will only be effective once actually received in our office. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment, or healthcare operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our *Notice of Privacy Policies* provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our *Notice of Privacy Policies* before signing this consent.

We reserve the right to amend the terms of our privacy policy. You may obtain a copy of the current policy by calling (417) 967-0900.

By signing this questionnaire, I authorize Advanced Care Physical Therapy to treat my condition as ordered by my physician, administer medications necessary for proper treatment, and understand that above practices of Advanced Care Physical Therapy.

****

Print Name of Patient: _____

Signature: _____ Date: _____

If you are signing as the patient's representative/guardian:

Print Name: _____

Relationship: _____

**If the patient is a minor (under 18 years of age) the signature of a parent/legal guardian is required.