



**Patient Health Information Consent Form:** The patient understands and agrees to allow Journey Physical Therapy to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.

The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections, please keep in mind that when requesting records a fee may apply. The patient may request to know what disclosures have been made. Should any restrictions be submitted in writing, our office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of 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.

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.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Journey Physical Therapy has the right to refuse care.

**Consent for Treatment:** I authorize and consent to any Physical Therapist for Journey Physical Therapy to perform Physical Therapy evaluation and treatments. I certify that no guarantee or assurance has been made as to the results that may be obtained. I have read and understand the above. I understand that I may stop treatment at any time.

**Insurance Information:** I authorize a release of any medical and/or patient information needed to determine benefits or benefits for related services to any insurance company, any other third party payer, state medical assistance agency and/or any other governmental private payer responsible for paying such benefits. I agree to pay for all my charges not covered.

I hereby give my consent to Journey Physical Therapy to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record.

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 Journey Physical Therapy.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. This policy will remain effective for the patient for the current plan of care and any future plans of care unless noted.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_