



Patient Name: _____ DOB: _____ Case #: _____

PATIENT INFORMATION ACKNOWLEDGEMENT FORM (HIPAA)

I have read and fully understand Fyzical-Southwest Sport and Spine, Inc. Notice of Information Practices which is posted and available for review. I understand that Fyzical may use or disclose my personal health information for the purposes consistent with the most current HIPAA regulations and practices. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice in writing. I also understand that Fyzical-Southwest Sport and Spine, Inc. will consider requests for restriction on a case-by-case basis but does not have to agree to requests for restriction.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Fyzical's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ **Initials**

CONSENT FOR PAYMENT TO FYZICAL

I request payment of authorized Insurance benefits be made either to me or on my behalf to Southwest Sport & Spine-FYZICAL for any services furnished me by the listed provider. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

_____ **Initials**

CONSENT TO MEDICAL PROCEDURES

The undersigned consents to the therapy performed at Fyzical-Southwest Sport and Spine, Inc. on an outpatient basis, for the patient by the therapy staff which may include but is not limited to medical treatment or procedures rendered of Fyzical, under the general and special instructions of the patient's physician.

_____ **Initials**

LEGAL RELATIONSHIP BETWEEN FYZICAL AND PHYSICIANS

Any physician providing services to the patient is an independent provider and is not an agent or employee Fyzical-Southwest Sport and Spine, Inc.

_____ **Initials**

CONSENT TO DOCUMENT OUTCOMES

As a patient of Fyzical. it is understood that photographs and/or videos may be used to document patient progress.

_____ **Initials**

CONSENT TO USE RESULTS IN MARKETING

May we use your therapy results and attribute them to you in future marketing? **Yes No**

_____ **Initials**

CONSENT FOR APPOINTMENT REMINDER

May we send you reminders for your appointments? **Yes No** Primary Phone number # _____

_____ **Initials**

 Patient Signature

 Date