PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Patterson Physical Therapy may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Patterson Physical Therapy complies with HIPPA laws regarding your PHI. I have the right to request a comprehensive copy of Patterson Physical Therapy's *Notice of Privacy Practices* prior to signing this consent. I understand that Patterson Physical Therapy reserves the right to revise its *Notice of Privacy Practices* at any time.

With my consent, Patterson Physical Therapy may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to clinical care.

With my consent, Patterson Physical Therapy may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements.

I understand that my PHI will be used in accordance with the policies outlined under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I have the right to request in writing that Patterson Physical Therapy restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

I understand that I have the right to revoke my consent in writing for use and disclosure of my PHI to carry out TPO except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I understand that Patterson Physical Therapy can support my care with a telemedicine visit which may include video conference meeting and/or phone conference conversation. I understand that my telemedicine visit(s) will follow all HIPAA regulations. Any telemedicine visit(s) will be billed to my insurance and I will be responsible for any copayments or coinsurances that apply.

I understand that if **I do not sign** this consent, Patterson Physical Therapy **may decline to provide treatment** to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Patient's Name (please print) Legal Guardian's Name (please print)