I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professional who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practice that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing. I have been provided with a complete copy of the Notice of Privacy Practice to review; and I acknowledge through my signature receipt of the Notice of Privacy Practice. The Notice of Privacy Practice was updated January 1st, 2016. Additional copies are available upon request at Gina V Physical Therapy Clinic.

The following persons listed are allowed to obtain treatment information and/or billing information associated with my treatment at Gina V Physical Therapy:

Spouse: Yes No Name:_____ Parent: Yes No Name:_____

Employer: Yes No Name:_____ Child: Yes No Name:_____

Other: Yes No Name:_____ Other: Yes No Name:_____

If I am unable to reached, I give permission to have messages regarding my appointment time, changes or, or scheduling information left as follows:

_____ on answering machine _____ on voice mail _____ with family member _____ at work

_____ via email:_____

I fully understand and accept the terms of this consent

Signature_____Date_____