



**CONSENT FOR MEDICAL AND ASSUMPTION OF RISK:**

I have been informed that participation in Physical Therapy (PT): may include exercises for strengthening, conditioning, flexibility, agility and may involve the use of equipment. Such participation has potential mental/ physical risks.

During my treatment at Advanced Physical Therapy I agree to the following:

- My participation in each exercise and activity is strictly voluntary and I may choose to limit my participation in any activity at any time.
- I am personally responsible for my own safety during PT. I will monitor and pace myself in a manner that is safe while still actively engaging in each activity.
- I will advise my Physical Therapist of any changes in my physical or mental health prior to participation in each session. I understand that failure to provide this information may have a negative effect with my treatment.
- My Physical therapist is available to answer any questions that I might have regarding my participation in PT and failure to ask these questions may negatively impact my treatment.
- I will seek further direction for anything that I do not fully understand, or that causes me concern.

I hereby accept the responsibility for any harm, injury, or damage that may result from my participation in PT. I hereby waive, release and agree to hold harmless Advanced Physical Therapy for any claim arising out of any injury to me.

**HIPAA CONSENT: Health Insurance Portability and Accountability Act**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations. You have a right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice has a Notice of Privacy Practices and the patient has an opportunity to review this notice
- The practice reserves the right to change the notice of privacy practices
- The patient has the right to request restricted use of their information
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters relating to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

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**Printed Name of Patient**

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**Signature of Patient or Guardian**

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**Date**

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**Reviewed By**