MFR Physical Therapy, LLC

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

The Healthcare Insurance Portability and Accountability act of 1996 ("HIPPA") is a federal program, which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misue personal health information.

We are required by law to maintain the privacy of your protect health information and to provide you with notice of our legal dutiesw and privacy practices with respect to protected health information.

As requred by "HIPPA", we have prepared this explanation of how we are requred to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-managment analysis, and customer service.

I understand and have been provided, (see poster at front of office), with Notice of Privacy Practicers that provdes a more complete description of in formation uses and disclosures. If I have any further questions in regards to the Privacy Practices I can contact the privacy officer.

I understand that MFR Physical Therapy, LLC is not requried to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organizaiton has already taken in reliance theron. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand the MFR Physical Therapy, LLC reserves the right to change their notice and practices and prior to implemetation, in accordance with Section 164.520 of the Code of Federal

Regulations. Should MFR Physical Therapy, LLC change their notice, they will send a copy of any revised notice to the address I have provided.

I wish to have the following restictions to the use or disclosure of my health information:_____

OK to speak with : _____

I understand that as part of MFR Physical Therapy, LLC treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via fax.

I fully understand and accept the terms of this consent.

Signature_____ Date_____