

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

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this office's policy to require your reading and signing this consent form prior to the provision of treatment or any other medical services. If you have any questions, please ask for the Privacy Official in this office.

I, \_\_\_\_\_, understand that as part of my health care, Caliente Springs Physical Therapy, Inc. originates and maintains paper and/or electronic 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 professionals 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 Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Caliente Springs Physical Therapy, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. 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 that Caliente Springs Physical Therapy, Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Caliente Springs Physical Therapy, Inc. change their notice, they will send a copy of any revised noticell to the address I've provided via U.S. mail.

I understand that as part of this organization's treatment, payment, or health care 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 disclosures via fax.

I understand that the office will NOT receive financial or in-kind compensation in exchange for using or disclosing the health information described above. (A fee of \$15 to \$25 will be charged for records released due to litigation purposes on behalf of our clients).

I fully understand and accept the terms of this consent.

\_\_\_\_\_  
Patient's Signature  
Signature of Legal Guardian if Patient is a Minor

\_\_\_\_\_  
Date