CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Dynamic Core Physical Therapy, P.C. to furnish medical care and treatment necessary and proper in diagnosing or treating my physical condition.

_____ _____
Signature of Patient/Guardian Date

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third-party payers, to Dynamic Core Physical Therapy, P.C. A photocopy of this assignment, including medical records, is information necessary to secure payment.

_____ _____
Signature of Patient/Guardian Date

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Dynamic Core Physical Therapy, P.C to obtain any and all medical records concerning my care from any physician, hospital or health care professional that has provided medical care to me in the past.
I also authorize Dynamic Core Physical Therapy, P.C to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself and/or child at anytime.

_____ _____
Signature of Patient/Guardian Date

ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the practice's "HIPAA Privacy Policy Notice", which describes the practice obligations to ensure the privacy of my health information. The HIPAA Privacy Policy Notice also describes how the practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the practice's HIPAA Privacy Policy Notice and to ask questions about it. I understand that the practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Policy Notice.

I further acknowledge that the practice can change its HIPAA Privacy Policy Notice in the future and that I can receive a copy of the practice's current Privacy Notice at anytime.

I understand that I have the right to request that the practice restrict its use and disclosure of my health information for treatment, payment or health care operations. If my restrictions are accepted by the practice, these restrictions will be binding on the practice. I also understand that the practice is not required to agree to my requested restrictions.

I do not request any restrictions on the practice's use and disclosure of my health information for treatment, payment, or health care operations. _____ (Initial)

By signing this form, I consent to the practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, and if I do, my revocation will not affect any actions the practice has already taken in reliance of this consent.

_____ _____
Signature of Patient/Guardian Date

{ } Patient chose not to sign acknowledgment
Reason: _____
_____
Office Staff acknowledging patients refusal to sign consent

FINANCIAL AGREEMENT

I _____ am currently experiencing financial hardship due to circumstances beyond my control, and I cannot afford to pay my co-payment and/or deductible payments at this time. I hereby agree to pay $_____ each visit to Dynamic Core Physical Therapy, P.C which will be applied to my co-payment and/or deductible amount.
I have read and agreed to the above.

_____ _____
Patient Signature Date