HIPAA
Consent to Use and Disclosure
of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Brunswick Physical Therapy or disclosed to others for the sole purpose of treatment or obtaining payment.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

Brunswick Physical Therapy may or may not agree to restrict the use or disclosure of your protected health information.

If Brunswick Physical Therapy agrees to your request, the restrictions will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected heath information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Brunswick Physical Therapy reserves the right to modify the privacy practices outlined in the notice. Patient will be notified prior to any modification.

Signature
I have reviewed this consent form and give my permission to Brunswick Physical Therapy to use and disclose my health information in accordance with it.

X _____
Name printed

X _____
Patient Signature

X _____
Date

_____ _____
Signature of patient guardian/representative **Relationship of patient guardian/representative**

Effective Date: This notice is in effect on or after June 1, 2009

Brunswick Physical Therapy, PLLC
New Patient Registration

Payment Policy

All co-pays are due at time of treatment.

Payment may be made by check or cash. (Checks can be made out to BPT). We will accept credit card payments if you have a Flex Spending Account (FSA) or Health Savings Account (HSA).

A **$20 service fee** will be charged for checks returned for any reason.

Any bills submitted to the patient are payable upon receipt and will be subject to monthly interest charges if not paid within 30 days

Attendance

Your regular attendance is critical to your success. If you find it necessary to cancel an appointment for any reason, we require 24 hours' notice.

No shows will be charged a $30 fee which is not covered under your insurance benefit.

3 No shows will consist in an immediate discharge from physical therapy.

I understand and agree to the office procedures outlined above.

X _____ X _____

Patient Signature/Responsible Party Date

Brunswick Physical Therapy, PLLC
New Patient Registration

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Brunswick Physical Therapy PLLC** all
(Primary Insurance Carrier)
insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Physical Therapist/Brunswick Physical Therapy the use of this signature on all insurance submissions.

X _____ X _____
Signature of Patient/Responsible Party Date

X _____
Printed Name