ADVANCED KINETICS
physical therapy + sports performance

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for Advanced Kinetics LLC, to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating my (or my child's) physical and/or mental condition.

Responsible Party Initials/date _____

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize Advanced Kinetics Physical Therapy to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Advanced Kinetics Physical Therapy from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between Advanced Kinetics Physical Therapy and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize Advanced Kinetics Physical Therapy, to release all information necessary, including medical records, to secure payment.

Responsible Party Initials/date_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND HIPPA POLICY

I have had full opportunity to read the Health Information Portability and Privacy Act. I understand that by signing this consent, I am giving my consent to Advanced Kinetics Physical Therapy to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and Advanced Kinetics Physical Therapy will always post the current notice at the clinic, on the website and have copies available for distribution. I understand Advanced Kinetics Physical Therapy has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Advanced Kinetics Physical Therapy.

Effective April 14, 2003, I, _____, hereby acknowledge receipt of Advanced Kinetics Physical Therapy's Notice of Privacy Practices. Initial _____

Indicated below are individuals whom Advanced Kinetics Physical Therapy may speak to regarding my treatment. Please list names. _____

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers you provide us? Yes: Home Mobile Work Other:_____ No _____

Responsible Party Initials/date_____

SIGNATURE for CONSENT

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the Consent for Care and Treatment, the Authorization to release all information necessary to secure payment and the Consent For Use and Disclosure of Health Information.

Patient / Guardian/Responsible Party Signature: _____**Date** _____