Consent for Purpose of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Back In Action Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Back In Action Therapy. I understand that diagnosis or treatment for me by Back In Action Therapy may be conditional upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operation of the practice. Back In Action Therapy is not required to agree to the restriction that I may request. However, if Back In Action Therapy agrees to a restriction that I request, the restriction is binding for Back In Action Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that Back In Action Therapy has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me,

I understand I have the right to review Back In Action Therapy's Notice of Privacy Practices prior to signing this document. Back In Action Therapy's Notice of Privacy Practices has been provided to me, via observation in lobby. A copy of this may be requested. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations at Back In Action Therapy.

Back In Action Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by request from Back In Action Therapy.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority