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familycarept@yahoo.com

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Patient Consent Form

I, ____________________________, give my consent for FCPT to use and disclose my Protected Health Info for the purpose of my treatment, payment, and healthcare operations.

My "protected Health Info" means my personally identifying data, including my demographic info, that is collected from me, created by or received from any source, including my physician, other healthcare providers, my health plan, my insurer, my employer, or a healthcare clearinghouse. The info can relate to my past, present or future physical or mental health or condition. This info is protected because it identifies me or there is a reasonable basis for believing that the information may identify me.

"Treatment" means for the purpose of diagnosing me, providing medical care to me, assessing my physical condition, recommending treatment or services, and delivering healthcare related services, products or supplies to me.

"Payment" means for the purposes of obtaining payment from me, and includes insurance coverage from my healthcare plan or insurer, reimbursement by my assignment of benefits from any programs to which I am entitled to health care coverage, and the process of determining eligibility for such coverage and benefits.

"Healthcare operations" means those professional, administrative and office activities required to be performed by FCPT to deliver medical services to me.

I understand that I have the right to decline to sign the consent form, and that if I do decline to sign it and provide the required consent, then the office of FCPT has the right to decline to provide medical services to me.

I understand that if I do sign this consent form, I have the right to revoke it, in writing, at any time, except to the extent that FCPT office may have already taken action in reliance on this consent.

I understand that I have the right to receive written copy of, and read and review FCPT Notice of Privacy Practices prior to signing this document. Their Notice of Privacy Practices has been provided to me, or is available from the Privacy Officer at Family Care Physical Therapy PO Box 896 Getzville, NY 14068.

I understand that the Notice of Privacy Practices describes examples of the types of uses and disclosures of my Protected Health Info that will occur in my treatment, payment of my healthcare bills and healthcare operations of FCPT. It also describes my rights and FCPT duties with respect to my Protected Health Info.

I understand that FCPT 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 calling the office and requesting a revised copy to be sent in the mail, by forwarding a written request to the address stated above or by asking for one in person.

Signature of Patient, Legal Guardian or Personal Representative ______________________________ Date:______________

Printed Name of Patient, Legal Guardian or Personal Rep.____

If FCPT has made a good faith attempt to obtain patient consent, but was unable to d/t emergency circumstances, please document the following:

Name of behalf of FCPT:**______________________** ***Dates Attempted:*****_____________________________**

Reason for inability to obtain consent despite diligent efforts:**____**

Please document the good faith attempts made:**____If Patient Refused to Sign Consent or Revoked Consent, please document and contact Privacy Officer.***