

Patient Authorization

Patient Name: _____ DOB: _____

Release of Information and Consent for Treatment

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment at ACB, LLC, DBA Bare Physical Therapy. I permit its owner/therapist to treat me in ways they judge are beneficial to me. I consent to the rehabilitation and related services at this clinic. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care. I give permission to Bare Necessities to release my information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided. I authorize Bare Necessities to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment. The signature below certifies that I have read and understand the above information. Initial: _____

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Bare Necessities. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. Initial: _____

Payment Guarantee

I agree to pay Bare Necessities for the services provided to me or the party named above. Payment will be in the form of cash, check or credit card. If using a credit card an additional 2% fee will be added to cover the cost of card processing. Payment is due at the time of service. Receipts can be provided upon request for patient insurance filing or health savings account payment. Initial: _____

Patient or Guardian Signature: _____