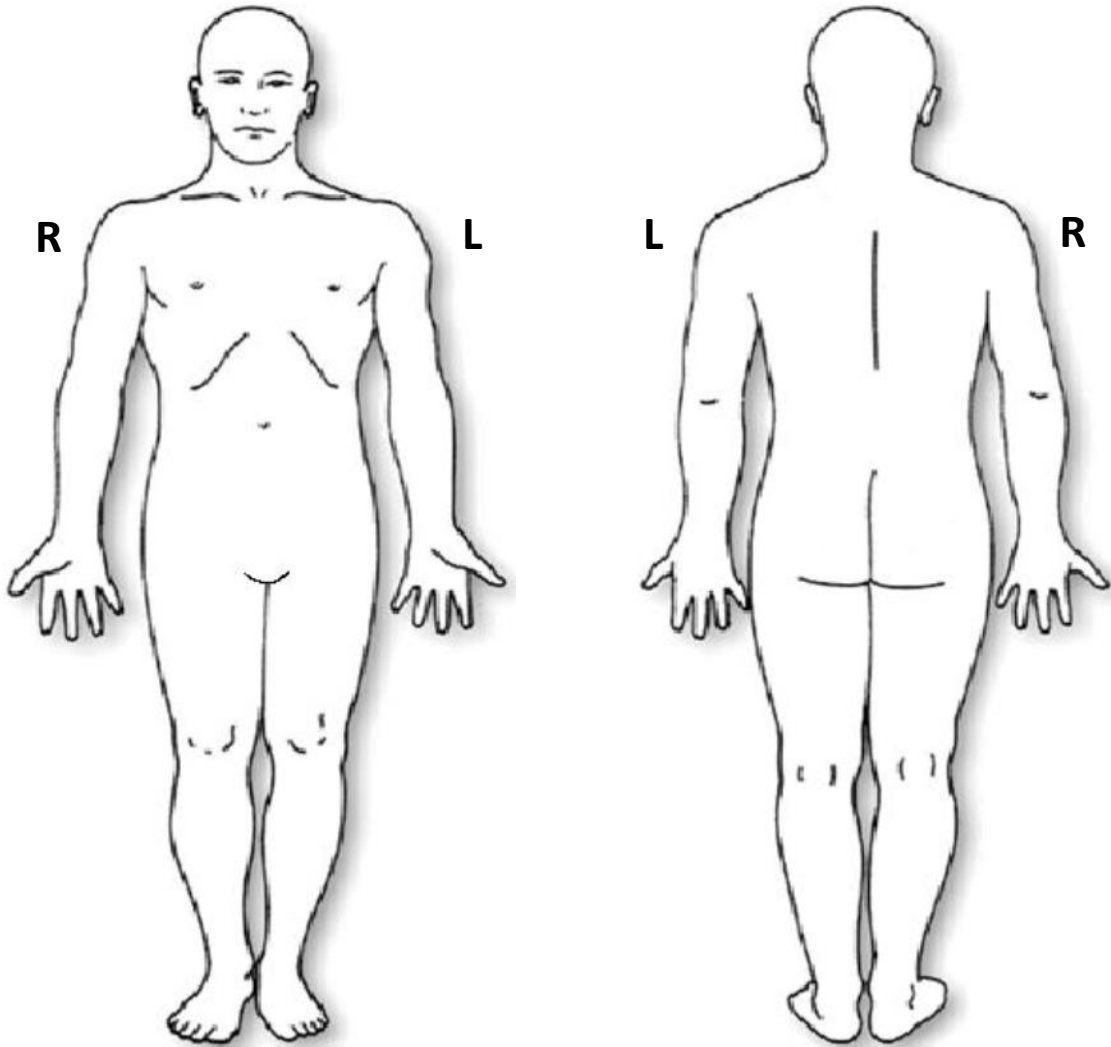


# Consent For Treatment and Pain Diagram

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_



**Please color in the areas where you feel pain**

**Consent for Treatment:** I hereby give written consent to be evaluated by a licensed physical or occupational therapist and treated by same therapist and/or his/her supervised physical or occupational therapist assistant or technician employed by this facility.

**Initials** \_\_\_\_\_

**If you are a Medicare patient:**

\*Are you currently receiving or have you recently received any health-related services at your home (home health nurse or aide)? Yes / No If no longer receiving, when were you discharged \_\_\_\_\_

If yes, with what agency: \_\_\_\_\_

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**Photo Consent (signature):** \_\_\_\_\_

There might be times that we ask to take a photo/video of you to document your progress or for marketing purposes. Your signature permits us to use photographs/videotapes for treatment and/or marketing purposes. It also releases us from any responsibility which may result from the taking of such images or any publicity which may result from the use of such images.

*Get Better Faster.....Stay Better Longer!*

Carlsbad Physical Therapy & Wellness Center, LLC.

**CARLSBAD PHYSICAL THERAPY & WELLNESS CENTER, LLC.**

**126 SOUTH CANYON  
CARLSBAD, NM 88220-5733**

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**Acknowledgement of Receipt of Privacy Notice**

**Purpose of this Acknowledgement**

This Acknowledgement, which allows the Clinic to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

***Please read the following information carefully:***

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by **Carlsbad Physical Therapy & Wellness Center, LLC.** (the "Clinic") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Clinic maintains a Privacy Notice which sets forth the types of uses and disclosures that the Clinic is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Clinic will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Clinic has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Clinic at the following address: 126 South Canyon Carlsbad, NM 88220-5733, Attention: Compliance Officer
4. I understand and acknowledge that I have the right to request that the Clinic restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Clinic is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Clinic agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Clinic's use and/or disclosure of my health information (leave blank if no restrictions):

\_\_\_\_\_

\_\_\_\_\_

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

**BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE CLINIC'S POLICY NOTICE AND AGREE TO THE CLINIC'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.**

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Name of Personal Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient

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**To Be Completed by the Clinic**

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

\_\_\_\_\_ Accepted      \_\_\_\_\_ Denied      \_\_\_\_\_ Not Applicable  
\_\_\_\_\_ Other (explain) \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Clinic Representative

\_\_\_\_\_  
Date