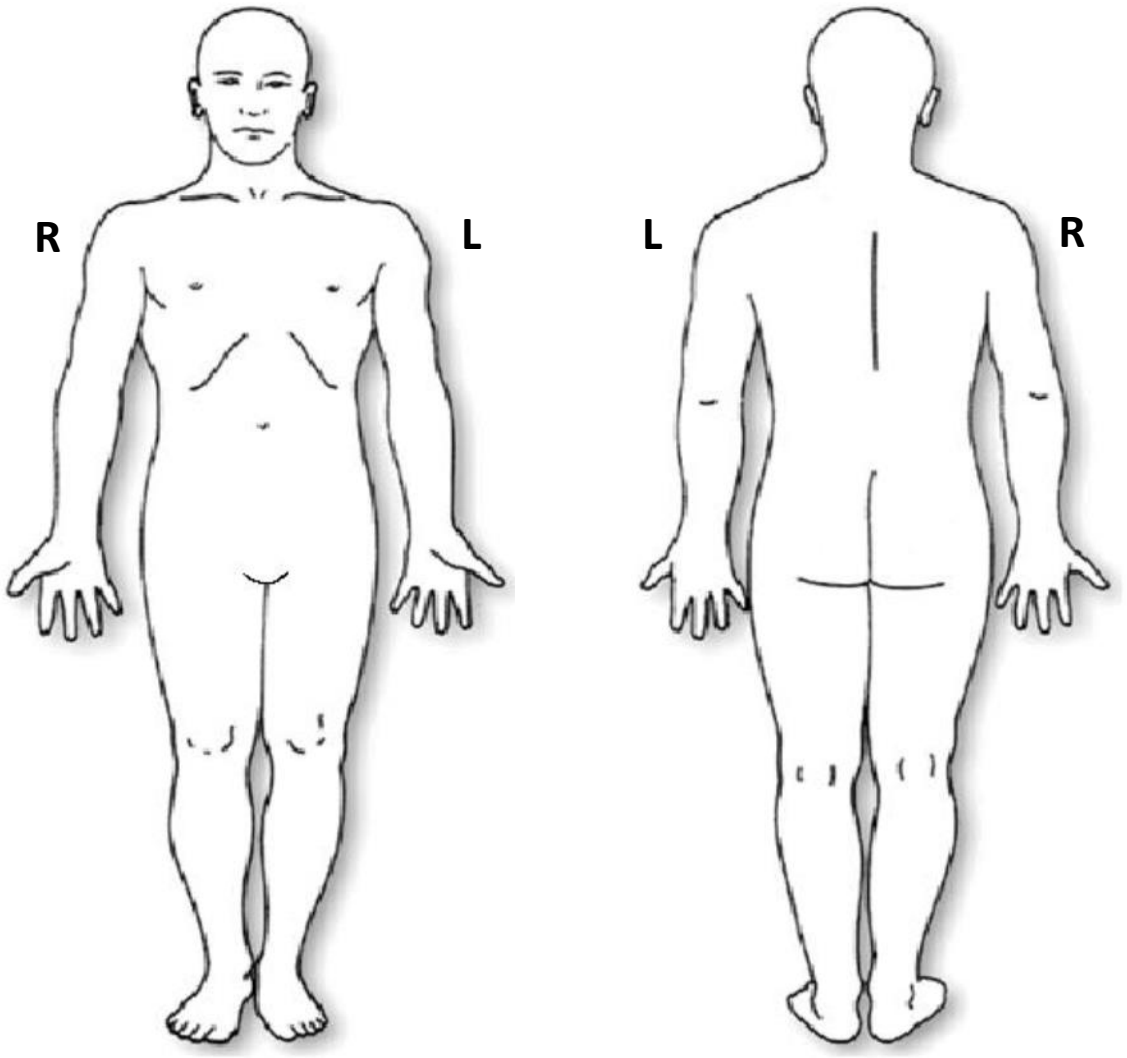
Consent For Treatment and Pain Diagram

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 any health-related services at your home (home health nurse or aide)? Yes / No

If yes, with what agency: _____

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!

Artesia Physical Therapy, LLC.

ARTESIA PHYSICAL THERAPY, LLC.
601 W. MAHONE
ARTESIA, NM 88210-2080

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 **Artesia Physical Therapy, 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: 601 W. Mahone Artesia, NM 88210-2080, 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

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