



# Renton Sports & Spine Physical Therapy

4361 Talbot Road So., Suite 100, Renton, WA 98055

Phone: (425) 917-9885 / Fax: (425) 917-2334

## **PATIENT CONSENT AND RELEASE OF MEDICAL AUTHORIZATION**

I hereby consent to treatment and evaluation by my physical therapist. I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending Labor and Industries claims. I understand the parent accompanying a minor for treatment will be responsible for payment. I authorize Renton Sports & Spine Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Lakeland Sports & Spine Physical Therapy for any benefits available under my insurance plan.

NAME (please print) \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
(relationship if patient is a minor)

### **ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my therapy provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my therapy provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restriction, but if you do agree than you are bound to abide by such restrictions.

NAME (please print) \_\_\_\_\_

SIGNATURE: \_\_\_\_\_  
(relationship if patient is a minor)

DEPENDENT FAMILY MEMBERS ALSO COVERED BY THIS ACKNOWLEDGEMENT:

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