Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Green Ridge Physical Therapy and Wellness. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. It is understood that this type of therapy involves the use of "touch" for both assessment and treatment and that the therapist will explain these approaches to the patient and answer any questions regarding the procedures.

Patient Information Consent Form (HIPAA) Green Ridge Physical Therapy and Wellness is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and abide by the terms of the notice that is currently in effect. GRPT may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that GRPT will consider requests for restrictions on a case-by-case basis but is not required to oblige to such requests. I hereby consent to the use and disclosure of my personal health information for purposes as noted in GRPT of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point GRPT has 30 days to respond to my request.

Release of Information I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original. I have read and fully understand GRPT notice of Information Practices.

Authorization to Disclose Medical Information I authorize my therapist and/or support staff at GRPT to discuss information related to my medical records and/or billing details with the following individuals. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below.

Authorized Individuals:

Name:____
Relationship:___________________ Information to be released (**circle one or both**) **RECORDS** **BILLING**

Name:____
Relationship:___________________ Information to be released **(circle one or both)** **RECORDS** **BILLING**

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals' authorization above.

Patient Signature ____ Date____________________