CONSENT FOR CARE AND PRIVACY PRACTICES ***TWO SIGNATURES REQUIRED***

CONSENT FOR CARE AND TREATMENT

I understand and agree that I am responsible to make payments on my account and if I fail to make any of the payments for which I am responsible in a timely manner, that I am responsible for interest as well as for all collection costs including but not limited to court costs, collection agency fees, and attorney fees.

I, the undersigned, do hereby agree and give my consent for Best Life Physical Therapy to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

*****SIGNATURE REQUIRED BELOW****

Patient/Guardian Signature:_____ DATE: _____

CONSENT TO TREATMENT OF A CHILD *(only fill out if patient is a minor)*

I hereby authorize Best Life Physical Therapy Physical Therapists and whoever they may designate as assistants to administer treatment to my son/daughter (circle one), _____ as they deem necessary and appropriate.

Signed: _____ DATE: _____

Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the "HIPPA Notice of Privacy Practices" for Best Life Physical Therapy and Sports Medicine. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law, I must give my written authorization to Best Life Physical Therapy and Sports Medicine to release any of my protected healthcare information.

My signature below acknowledges that I have read this document and understand the responsibilities I am expected to uphold, and understand my rights as described herein.

*****SIGNATURE REQUIRED BELOW****

Patient/Guardian Signature: _____

DATE: _____ Patient/Guardian Printed Name: _____