Jason A. Campopiano, PT, PLLC

CONSENT TO CARE

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ("PHI")

1. Patient Consent to Care: I the undersigned do hereby consent to treatments and procedures as deemed necessary by my provider, Local Motion Physical Therapy ("LMPT"), and its agents. I do consent to treatments and procedures which may be different or in addition to those initially discussed or contemplated, if said treatments or procedures are deemed necessary or advisable by LMPT and its agents during the course of treatment.
2. Patient Consent for Use and Disclosure of PHI: I the undersigned do hereby consent to LMPT and its agents to use and disclose my PHI to perform treatments, payment or other health care processes, as determined at the sole discretion of LMPT and its agents. I do consent to my medical record being released to another provider who is involved with treatment, payment or healthcare processes, as determined at the sole discretion of LMPT and its agents.
3. Patient consent to Release of Billing Information over the telephone: I do consent that LMPT or its agents may disclose billing information to any agency, provided that said agency provides my correct SSN# or health plan #.
4. Permission to call and leave voicemail: I do consent that LMPT or its agents may call and leave voice mail at my home or other number I provide, regarding appointments, billing or payments, or other information including treatments or health care processes.
5. Permission to discuss PHI with third parties: I do consent that LMPT and its agents may discuss my PHI with any person(s) who accompanies me to a visit or treatment or is in my presence when the provider is present. I also consent that my provider may discuss my PHI with any person who identifies him/herself as active in my care including but not limited to family, friends, clergy, patient advocates. I do consent that the provider may disclose my PHI to an employer who arranges or pays directly or indirectly for my treatment.
6. Permission to discuss the PHI of a minor: I do consent that LMPT and its agents may discuss a child's PHI with a person accompanying the child. I agree that LMPT and its agents may discuss PHI with parents and stepparents.
7. Permission to discuss PHI with Public Agencies: I do consent that LMPT and its agents may, upon request by the following agencies, disclose my PHI to public health and law enforcement agencies, and the Food and Drug Administration.
8. Notice of Privacy Practices: I am aware that I can request a copy of this agreement which provides LMPT's privacy practices and my rights regarding privacy of my PHI upon request.

Signature____Date__________________________