



PATIENT INFORMATION CONSENT FORM

I have read and fully understand One-on-One Therapy's Notice of Information Practices. I understand that One-on-One Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the One-on-One Therapy in writing. I also understand that One-on-One Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in One-on-One Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying One-on-One Therapy in writing at any time.

Patient Name (print): _____ Date: _____

Signature: _____

PATIENT PRIVACY NOTICE

HIPPA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification Section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers.
- Healthcare Transaction & Code Sets for transmitting data electronically.
- Privacy regulations over disclosure and use of health information.
- Security regulations over protections of electronic health information.

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself please complete the following:

I, _____, hereby authorize One-on-One Therapy's staff to leave medical information pertaining to my care by telephone, email or voicemail and will assume responsibility to notify them whenever this information changes.

Signature: _____ Date: _____

CONSENT TO TREATMENT

I do hereby consent to such treatment by the authorized personnel of One-on-One Therapy as may be dictated by prudent medical practice by my illness, injury or condition. This is intended as a waiver of liability for such treatment excepting acts of negligence.

Signature: _____ Date: _____