Patient Name	Patient ID

ONSITE PHYSIO, LLC

CONSENT FOR TREATMENT AND USE AND DISCLOSURE OF HEALTH INFORMATION

1. Consent to Treatment. I hereby authorize ONSITE PHYSIO, LLC ("OP") to perform physical therapy procedures and render appropriate treatment as prescribed by my physician. I understand and acknowledge the following:

The nature of the treatment and/or procedure(s) to be performed has been fully explained to me.
The most likely or frequent risks of the proposed treatment or procedure(s) have been explained to me, including the risk that such treatment may not accomplish the intended result.
The possible or likely consequences of undergoing the treatment or procedure(s) have been explained to me.
No guarantees have been made to me regarding the results of the treatment or procedure.
Reasonable alternative treatments and the possible consequences of such alternatives have been explained to me.
I have had the opportunity to ask questions concerning my condition and the proposed treatment or procedure(s), and all of my questions have been answered to my satisfaction.

2. Use and Disclosure of PHI. OP obtains and maintains health information relating to my past, present or future physical or mental condition, provision of health care or payment for health care, referred to as "Protected Health Information" or "PHI". This PHI may be used or disclosed by OP for purposes of treatment, payment or health care operations, including, but not limited to, planning for my care and treatment; calling me with appointment reminders and lab results; submitting a claim to my insurer or health plan; and assessing the quality of care provided to me.

3. Authorization for Photographs. I hereby authorize OP to take photographs as needed for the purposes of documentation of the treatment and services I will receive.

4. Insurance Benefits and Payment. I hereby authorize my workers' compensation insurance carrier to pay insurance benefits to OP.

I have been admitted through my workers' compensation insurance, financial responsibility is: $0 ____ (initial)

I acknowledge that I have been explained and understand the financial information indicated above, which is related to the payments made by an insurer or third party payor, the scope and intent of coverage and the charges for non-covered service charges.

5. Acknowledgement. I acknowledge that I have read this consent in its entirety, or it has been read to me and that the explanations referenced herein were made tu me. I acknowledge that I fully understand the contents and meaning of this consent.

By signing this form, I consent to the performance of the physical therapy procedure(s) or and treatment and OP' use and disclosure of my Protected Health Information.

WITNESS: **PATIENT:** **DATE:**

______________________ ______________________ __________

PARENT OR LEGAL GUARDIAN*

____

(*If patient is a minor or incompetent to give consent.)

NOTICE OF PROVIDER PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OnSite Physio, LLC must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

However, we reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised copy.

<u>Without your written authorization</u>, we can use your health information for the following purposes:

1. **Treatment:** The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care.
2. **Payment:** In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you.
3. **Health Care Operations:** We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver.
4. **As required or permitted by law:** At times we must report some of your health information to legal authorities, such as law enforcement or court officials, or government agencies.
5. **For public health activities:** We may be required to report your health information to authorities to help prevent or control disease, injury, or disability. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.
6. **For health oversight activities:** We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.
7. **For activities related to death:** We may disclose your health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death.
8. **For organ, eye or tissue donation:** We may disclose your health information to people involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation purposes.
9. **For research:** Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
10. **To avoid a serious threat to health or safety:** As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.
11. **For military, national security, or law enforcement custody:** If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials, we may release your health information to the proper authorities so they may carry out their duties under the law.
12. **For workers' compensation:** We may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.
13. **For OnSite Physio's directory:** Unless you object, we may use your health information, such as your name, location in our facility, and your general health condition (e.g., "stable," or "unstable"). It is our duty to give you enough information so you can decide whether or not to object to release of this information for our directory.
14. **To those involved with your care or payment of your care:** If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your medical bills, we may release important health information about you to those people. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status.

NOTE: Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information

If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to the Privacy Officer.

<u>Your Health Information Rights</u>

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact the Privacy Officer. Specifically, you have the right to:

1. **Inspect and copy your health information:** With a few exceptions, you have the right to inspect and obtain a copy of your health information. In addition, we may charge you a reasonable fee if you want a copy of your health information.
2. **Request to correct your health information:** If you believe your health information is incorrect, you may ask us to correct the information. You may be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.
3. **Request restrictions on certain uses and disclosures:** You have the right ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. Or, you may want to limit the health information provided to family or friends involved in your care or payment of medical bills. You may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to your requested restriction.
4. **As applicable, receive confidential communication of health information:** You have the right to ask that we communicate your health information to you in different ways or places.
5. **Receive a record of disclosures of your health information:** In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003.
6. **Obtain a paper copy of this notice:** Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically.
7. **Complain:** If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact the Privacy Officer, who will provide you with the necessary assistance and paperwork.

Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact the Privacy Officer at (904) 357-5120.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that OnSite Physio, LLC has given you a copy of its Notice of Privacy Practices, which explains how your health information will be handled in various situations.

Patient Name ____________ Patient Signature ____________ Date ____________

OFFICE COPY

*PLEASE DO NOT ALLOW ACCESS TO MANAGE PATIENTS **WebPT**™

WebPT Digital Signature Form

I, ______________________________ (Print), hereby authorize the use of the below signature as my legal digital signature for physical therapy documents created by me on WebPT.com.

First Name: ______________________________

Middle Initial: __________

Last Name: ______________________________

State License #: ______________________________

NPI #: ______________________________ You can search or apply for an NPI # at: nppes.cms.hhs.gov

Email: ______________________________

Clinic Name: ONSITE PHYSIO

Clinic City, State: ____________________, ______________

User Type (circle): Therapist Therapist Assistant Student

☐ New Signature ☐ Replacement Signature

Please sign inside the box below. *Sign **your normal signature size without touching the lines** and sign as close to your real signature as possible.*

Please Return to Onsite Physio:
By Fax: 866-908-4797
By Scan and Email: referrals@onsite-physio.com