HODGES
PHYSICAL THERAPY

CLIENT CONSENT FORM

CONSENT TO TREAT

I hereby grant consent for treatment or services provided by Hodges Physical Therapy.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that my personal health information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or, the Family Education Rights and Privacy Act (FERPA) and may not be disclosed without either my authorization or consent.

I understand that my protected health information will, or could be used for purpose of providing information, and communication with other health providers on your behalf.

FINANCIAL POLICY

I understand payment for Hodges Physical Therapy's services are due at the time the services are rendered.

RESPONSIBLE PARTY'S SIGNATURE _____ TODAY'S DATE _____

NAME (PLEASE PRINT) _____ DATE OF BIRTH _____

ADDRESS _____ CITY/STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL ADDRESS _____

EMERGENCY CONTACT NAME _____ PHONE _____