MONTCLAIR PHYSICAL THERAPY INC.

ACTIVE METHOD PHYSICAL THERAPY

GET AMPT • BE STRONG

# *CONSENT ACKNOWLEDGEMENT*

***For Purposes of Treatment, Payment, & Healthcare Operations***

*I consent to the use or disclosure of my protected health information (PHI) by* ***Montclair Physical Therapy, Inc. (MPT) & Active Method Physical Therapy (AMPT)*** *for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of* ***MPT/AMPT.*** *I understand that diagnosis or treatment of me by* ***any licensed Physical Therapist (PT), or Physical Therapy Assistant (PTA) employed by MPT/AMPT*** *may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of the practice.* ***MPT/AMPT*** *is not required to agree to the restrictions that I may request. However, if* ***MPT/AMPT*** *agrees to a restriction that I request, the restriction is binding on* ***Montclair Physical Therapy, Inc. & AMPT and any licensed PT, or PTA employed by MPT/AMPT.*** *I have the right to revoke this consent, in writing, at any time, except to the extent that* ***any licensed PT, or PTA employed by MPT*** *has taken action in reliance on this consent.*

*My "protected health information" (PHI) refers to my health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health condition and identifies me (or there is a reasonable basis to believe the information may identify me). I certify all PHI shared with* ***MPT/AMPT*** *is, to my best knowledge, correct and true and I understand my responsibility to inform* ***MPT/AMPT*** *of any changes. I consent to the use of my PHI, especially my contact information regarding my treatment in conjunction with* ***MPT's/AMPT's*** *automated appointment and treatment notification system.*

*I understand I have a right to review* ***MPT's/AMPT's*** *Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of* ***MPT/AMPT.*** *This Notice of Privacy Practices also describes my rights and* ***MPT/AMPT*** *duties with respect to my protected health information.* ***MPT/AMPT*** *reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.*

***MPT/AMPT requires 24-hour notice for cancellations of scheduled appointments****.* ***MPT/AMPT*** *understands scheduling conflicts and emergencies can occur and is committed to accommodating my schedule with high priority. I understand my plan of care is unique and attendance in completing each course of treatment has a direct effect on my recovery potential. Timely communication in accordance with this policy is greatly appreciated.* ***MPT/AMPT*** *is here to help me be my best.*

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| ***Signature of Patient/Personal Representative*** | ***Name of Patient*** |
| ***Date*** | ***Name of Personal Representative & Relationship to Patient (if applicable)*** |

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