

**CONSENT FOR CARE AND TREATMENT
NOTICE OF PRIVACY ACT
BENEFIT ASSIGNMENT / RELEASE OF INFORMATION**

I, the undersigned, do hereby agree and consent for Progressive Physical Therapy Center to furnish medical care and treatment to _____, considered necessary and proper in diagnosing or treating his/her physical condition.

Progressive Physical Therapy Center will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. We have prepared a Privacy Notice to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will post the current notice in our facility, and have copies available for review and distribution. The undersigned acknowledges receipt of this information.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Progressive Physical Therapy Center. A photocopy of this agreement is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, in order to insure payment.

X _____
Patient/Guardian/Responsible Party **Date**

When it comes to your medical treatment, we strive to communicate with you in as timely and professional a manner as possible. There are certain occasions when family members, friends, or others might be involved in your care. As a patient, you will want our facility to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other people with whom we can discuss your care and share your protected health information.

PLEASE LIST BELOW ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS ASPECTS RELATED TO YOUR CARE.

Name: _____ Relation to patient _____

Name: _____ Relation to patient _____

Name: _____ Relation to patient _____

X _____
Patient/Guardian/Responsible Party **Date**