



## Consent for Care

I, the undersigned, do consent to physical therapy treatment as ordered by physician prescription and administered by Excel Orthopedic Rehabilitation (EOR).

### Consent for Use and Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information by EOR for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me 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 protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. EOR is not required to agree to the restrictions that I may request. However, if EOR agrees to a restriction that I request, the restriction is binding on EOR. Your request must be in writing and you must state the specific restriction requested and to whom you want the restriction to apply.

I have the right to revoke this consent, in writing, at any time, except to the extent that EOR has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical therapy or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review EOR's Notice of Privacy Practices prior to signing this document. EOR's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care operations of EOR. This Notice of Privacy Practices also describes my rights and EOR's duties with respect to my protected health information.

EOR 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 a revised copy be sent in the mail or asking for one at the time of my next appointment.

Please be advised that EOR practices in an open gym environment. This means that if your treating provider is discussing your private health information with you, someone in close proximity may overhear the conversation. If you are concerned with this, please bring this to the attention of your therapist.

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Patient signature (or parent if minor)

Date