PATIENT PRIVACY & CONSENT TO TREATMENT

I indicate that I have received and read a copy of the HIPAA Privacy and Disclosure Notice and, if requested it has been explained to me.

Additionally, my signature below authorizes IPA Physio to release my medical records and any relevant information to my insurance company for reimbursement.

Lastly, my signature indicates my permission to be evaluated and treated by a licensed physical therapist at IPA Physio.

Patient's Name (*please print*): _____

Signature: _____ Date: _____