Acknowledgement of Privacy Practices

I have received read and understood the notice of privacy practices which has provided a complete description of the uses and disclosures of my health information as outlined by the Health Insurance Portability and Accountability Act of 1996. I understand that I have certain rights regarding my protected health information and that this information can and will be used for purposes of treatment, payment and normal healthcare operations.

Patient name : ____

Signature : ____

Date: _________________

Consent to Treatment

I give my consent for treatment of the medical condition for which I have consulted Momentum Physical Therapy. I consent to receive all treatment provided according to generally accepted standards of medical practice. I understand that I cannot be given a guarantee regarding the results of this treatment. I understand that I will be given the opportunity to discuss the details of my treatment plan with the therapist prior to the initiation of treatment

Patient signature: ____

Legal Guardian signature: ____

Date: __________________