Revised 3/2003
Visions Physical Therapy
2475 Lakeland Dr. Ste A
Jackson, MS 39232

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996, (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certification

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses of disclosures of my health information. I understand that **Visions Physical Therapy** has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this **Visions Physical Therapy** at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____