

Bonnette Elite Physical Therapy and Wellness, PLLC

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CONSENT TO USE AND DISCLOSE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to Bonnette Elite Physical Therapy and Wellness' (BEPTW) use and/or disclosure of my protected health information (PHI) in support of my diagnosis and treatment; payment for physical therapy services I receive from BEPTW ; and the healthcare operations of BEPTW. Further, I hereby authorize BEPTW to administer such physical therapy procedure necessary to the reasons for which I am consulting them. Other disclosures of my PHI, including without limitation those relating to mental health, HIV/AIDS status or substance abuse, if any, may require me to sign a separate authorization.

I hereby authorize insurance payments directly to BEPTW for credit to my account. If my policy prohibits direct payment to the provider, then I hereby instruct that the check made payable to me be forwarded to BEPTW.

I understand that I am financially responsible for any and all charges not covered by my insurance plan(s). I understand that any dispensed supplies not paid by my insurance company will be my responsibility. If my account is referred for collection, I will be responsible for all fees required to collect it (including attorney's fees). I authorize BEPTW to release and discuss any information necessary to process claims on my behalf.

I hereby authorize BEPTW to obtain or release and discuss any information produced while in treatment at BEPTW from/to physicians, home health agencies or any other health care team members responsible for my past, present or follow up care.

I understand that BEPTW's agreement to provide physical therapy services to me is conditioned on my signing this consent to ensure that BEPTW can accomplish its professional responsibility of providing care to me.

I understand that BEPTW will use and/or disclose only the minimum amount of my PHI which is necessary, in BEPTW's sole judgment, for the specific needs of the recipient of for my general healthcare needs.

I do do not give my consent for my therapist to discuss my treatment with the following family members:

1. _____ 2. _____

With this Consent, BEPTW may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist BEPTW in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care. Also, subject to any applicable restrictions, BEPTW may release to me copies of pertinent medical reports such as X-Ray or MRI reports that are relevant to my care, if I request them to do so.

My signature indicates consent in the event that BEPTW be obliged to release and discuss to my employer any information pertinent to treatment of an employment-related compensable injury. However, release of such information is limited to said compensable injury.

We require 24-hour notice for all cancellations.

If you miss your scheduled appointment time, without giving prior notice of cancellation, a \$25.00 "No Show" fee can be charged to your account. Said charge is not covered by insurance and will be the patient's responsibility.

I understand that:

- I can revoke my consent at any time prior to the release of records by delivering written, signed and dated notice of my wishes to BEPTW except to the extent BEPTW has acted in reliance on any consent. A decision to withdraw my consent to release records, however, may be the basis for a denial of health benefits or insurance coverage or benefits.
- I can refuse to disclose some or all of my records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. Partial or incomplete records will be labeled as such to inform the provider receiving them of their status.
- I can restrict BEPTW's use and/or disclosure of my PHI, and that BEPTW is not required to agree to my restriction, but that BEPTW's agreement to such restriction is binding on BEPTW.

*If I have any questions about or would like a copy of this Consent or about BEPTW's privacy practices, I may ask the Office Manager.

I have reviewed and understand my rights/responsibilities as described above. Consent is valid for 30 months unless I revoke it prior to that expiration. Expires: _____ (month/day/year)

Signature: _____ Date: _____

Print Name: _____

Print Name of Representative: _____ Relationship: _____