SMaRT Therapy

Waycross, Georgia

Patient:_____ Date of Birth_____

AUTHORIZATION

I, the undersigned certify that I (or my dependent) has insurance coverage as listed above and assign directly to SMaRT. I understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of co pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize SMaRT to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature_____**Date**_____

Are you the Guarantor? Yes__ No __ If not please see receptionist.

CONSENT FOR TREATMENT

Having voluntarily presented myself (or my dependent) to SMaRT, I acknowledge recognition of the fact that the evaluation and treatment received, advised or deemed necessary, to be the judgment of the Physical Therapist.

X Signature_____**Date**_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA)

By signing this form ,you acknowledge that SMaRT has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled in a various situation .We must attempt to have you sign this form on your first date of service with us after April 14,2003. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

☐ **I have received a copy of the Privacy Notice of SMaRT Therapy.**

☐ **SMaRT Therapy has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.**

X Signature_____**Date**_____

ADDITIONAL PERSON(S) AUTHORIZED TO MAKE THE USE OR DISCLOSURE OF MY PERSONAL HEALTH INFO

We at SMaRt value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (Including spouses, parents, children, or any significant others without your written consent). If you want anyone other than your referring physician to have access to your medical information please list their name, address, relation, and phone number below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name _____ Relation _____
Name _____ Relation _____
Name _____ Relation _____

X Signature_____**Date**_____

☐ **This will never expire** ☐ **This will expire on** _____

The staff of SMaRT Therapy should complete this section if Acknowledgement Form is not signed by the Patient:

1. Does the patient have a copy of the Privacy Notice? **Yes__ No __**
2. Please explain why the patient was unable to sign an acknowledgement form and our efforts in trying to obtain the patient signature: _____

Employee Signature: _____ Date _____