



Patient Name: \_\_\_\_\_ Patient Phone \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Patient Rights & Responsibilities**

I acknowledge the receipt of information pertaining to my right to accept or decline the disclosure of my personal health information that is protected by HIPPA policy to PT Link, LLC. In granting my permission, I will allow my personal health information to be shared with PT Link LLC, to screen for any physical or environmental needs that may or may not be present.

**Consent for Treatment**

I hereby give my permission for authorized personnel of PT Link, LLC to perform all necessary procedures to assess for any needs delivered via physical therapy care. If applicable, I understand my physician will be contacted and services will be rendered through PT Link. I understand that PT Link will supervise services provided, I may refuse treatment or terminate services at any time, and PT Link may terminate their services to me as explained in my orientation. I agree and consent to allow my personal health information to be shared with PT Link. In doing so, I consent to allow a professional from PT Link including but not limited to physical therapy assess my needs.

**Release of information**

I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that PT Link may use or disclose protected health information from insurance companies, health plans, Medicare, Medicaid, or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services, any person or entity affiliated with or representing for purposes of administration, billing, and quality and risk management; any hospital, nursing home, or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care: family members and other caregivers who are part of my plan of care; licensing and accrediting bodies, and other health care providers in order to initiate treatment.

**Consent to Photograph**

I hereby consent for PT Link to take pictures of myself, and treatment being done and consent to the release of those photographs for use in advertisement or public education regarding physical therapy services or to insurance providers to document my medical condition.

**Advance Directives**

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive (Living Will/Durable Power of Attorney for Health Care) so that my wishes may be known when I am unable to speak for myself.

1. I have made a Living Will \_\_\_No \_\_\_Yes (if yes, provide a copy to the agency.)

2. I have made a Durable Power of Attorney for Medical Care \_\_\_No \_\_\_Yes (If yes, write the name & phone number of the person given power of attorney.

**I authorize PT Link, LLC to use and disclose the protected health information described above to the following individuals:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I understand a copy of this consent form shall be as valid as the original and shall remain in effect until I am discharged from PT Link care. I also understand that I may revoke this consent in writing at any time.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Responsible person or legal guardian's signature/person Authorized to sign

\_\_\_\_\_  
Witness Signature/Agency Representative

\_\_\_\_\_  
Printed Name & Relationship of Person Above

Patient unable to sign due to \_\_\_\_\_