

WILMINGTON PHYSICAL THERAPY, INC.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Wilmington Physical Therapy, Inc.'s Notice of Information Practices. I understand that Wilmington Physical Therapy, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Wilmington Physical Therapy, Inc. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restriction.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Wilmington Physical Therapy, Inc.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

PLEASE ANSWER ALL QUESTIONS, THANK-YOU!

(PATIENT SIGNATURE)

(DATE)

(PARENT/GUARDIAN SIGNATURE)

(DATE)

(PRINT PATIENT NAME)

DO WE HAVE PERMISSION TO:

LEAVE A MESSAGE ON YOUR HOME ANSWERING MACHINE? [] YES [] NO

LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? [] YES [] NO

DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD? [] YES [] NO

ANNOUNCE YOUR NAME OVER INTERCOM TO YOUR THERAPIST? [] YES [] NO

