Kansas Osteopractic and Wellness Patient Information Consent Form

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Kansas and Osteopractic and Wellness (KSOAW). The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment

Patient Information Consent Form (HIPAA)

I have read and fully understand KSOAW Notice of Information Practices. I understand that KSOAW may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that KSOAW will consider requests for restrictions on a case by case basis but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in KSOAW Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point KSOAW has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Designated Individuals Authorization

I, _____, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below.

Authorized Designees:

Name:_____ Date: _____

Name:_____ Date: _____

Patient Signature _____ Date: _____