HAND TO HAND THERAPY CLINIC, LLC
PATIENT INFORMATION CONSENT FORM

HIPAA POLICIES & PROCEDURES

I have read and fully understand **Hand to Hand Therapy Clinic, LLC's** Notice of Privacy Practices. I understand that Hand to Hand Therapy Clinic, LLC may use or disclose my personal health information for the purpose 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 **Hand to Hand Therapy Clinic, LLC** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Hand to Hand Therapy Clinic, LLC'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.

_____
Patient Name

_____ _____
Signature (or patient representative*) Date

For Practice Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
□ Individual refused to sign
□ Communication barriers prohibited us from obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please Specify)

* If patient representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

SUPPLIES AND EQUIPMENT

I agree to pay for hand therapy supplies, orthotics, braces or equipment in full on date of services. I understand that **Hand to Hand Therapy Clinic, LLC** does not have a contract with my insurance company to provide supplies, orthotics, braces, equipment or any durable medical goods. I understand that I will only be reimbursed the amount of money paid to Hand to Hand Therapy Clinic, LLC by insurance.

Signature_____Date_____

PRESCRIPTION AND/OR AUTHORIZATION WAIVER

I understand that if I do not have a current prescription from my physician or authorization from my insurance company for hand therapy that my insurance may choose not to pay benefits. I will then be financially fully responsible for payment.

Signature____Date___________________