

**Physical Therapy 180°**

5909 W. State St.

Boise, ID 83703

(208) 343-7700 Fax: (208) 331-2591

Thank you for choosing Physical Therapy 180° for your health needs; we appreciate you putting your trust in us. Please read the following brief notice and sign to indicate your acknowledgement and permission.

**Office Visit Policy:**

We request that in consideration of your therapist and other patients, you not wear any scent or perfume to your appointment.

Please call twenty-four hours in advance of your appointment to make any changes or cancellations. Any appointment cancelled on the day it occurs will be subject to a \$35 fee.

If you would like to receive our e-mail newsletter, please enter your e-mail address on the line indicated below.

**Privacy Practices Summary:**

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following right:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communication;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

**Patient Authorization for Use and Disclosure of Protected Health Information (PHI)**

This authorization permits **Physical Therapy 180°** to use and/or disclose the following individually identifiable health information about me: date(s) of services, type of services, pertinent medical records, and/or account information. The information will be used or disclosed for the following purpose(s): as required by law, at my request, for insurance purposes, for legal claims against a third party, and/or for co-ordination with my other medical practitioners. The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

**Physical Therapy 180°** may receive payment or other remuneration from a third party in exchange for using or disclosing the PHI; this remuneration will be limited to the cost of providing copies and/or postage for material requested.

I do not have to sign this authorization in order to receive treatment from **Physical Therapy 180°**. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at the above address.

Signed by:

\_\_\_\_\_  
Signature of Patient or Legal Guardian      Relationship to Patient

\_\_\_\_\_  
Print Patient's Name      Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian, if applicable

\_\_\_\_\_  
E-mail address