ALTITUDE PHYSICAL THERAPY, INC.
INFORMED CONSENT/PRIVACY POLICY

Authorization for Medical Treatment: I authorize the physical therapist(s) responsible for the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. This authorization includes, but is not limited, routine diagnostic procedures, the use of physical modalities, and the prescription of therapeutic exercise. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician or physical therapist whose care the patient is under.
I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to results of examination and treatment in Altitude Physical Therapy, Inc. I acknowledge that my care is under the direction of my treating physician(s) in the provision of said care.
Assignment of Facility Benefits: I/we assign all benefits to Altitude Physical Therapy, Inc. and authorize direct payment to Altitude Physical Therapy, Inc., 3151 E. Greenhurst Rd. Nampa, Idaho 83686, all insurance benefits, or Medicare/Medicaid benefits to which I/we may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. It also specifically includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I/we agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.
Statement of Responsibility: I understand that I am financially responsible to Altitude Physical Therapy, Inc. as the patient, parent, guardian, conservator, or insured for all charges not covered by the above assignment. These charges may include any medical insurance deductibles, co-pays, and/or co-insurance. I understand that to sign as a Guarantor means that if the patient does not pay Altitude Physical Therapy, Inc. for all services due, I, as Guarantor, will be responsible for such payment. I further understand that payment is due 30 days after receiving the billing statement; if there has been no payment toward my account in excess of 60 days, there may be levied interest and/or late fees at the current rate allowed by law. **Please make payment arrangements with our billing office if needed to keep your account in good standing.**
Authorization to Release Information to Insurance Company/Third Party Payer: I authorize Altitude Physical Therapy, Inc. and any physical therapist, practitioner, or other person, any hospital including Veteran's Administration or governmental hospital any medical service organization, any insurance company, or any other institution or organization to release any medical information about the patient necessary to determine any benefits which may be payable for this treatment.
HIPAA Acknowledgement: I hereby acknowledge that I have received a copy of the Notice of Privacy Practices as required by HIPAA.
Authorization for Quality Review: I acknowledge that it may be appropriate for Altitude Physical Therapy, Inc. to review the overall care provided to the patient following the cessation of treatment. I understand that this review is for the sole purpose of maintaining and improving the overall quality of care provided to Altitude Physical Therapy, Inc. patients. Therefore, I authorize the physical therapists and/or representatives of Altitude Physical Therapy, Inc. through their process Improvement Initiative to review copies of records regarding my care in order to establish clinical pathways and improved standards of care.
Personal Valuables: Altitude Physical Therapy, Inc. shall not be liable for the loss of or damage to any personal property.

The undersigned certifies that he/she has read the foregoing or is the parent or duty authorized by or on behalf of the patient to execute the above and accept its terms.

Patient's Signature/Parent if Minor/Power of Attorney	Date
Responsible Party's Signature (if not same as patient or parent)	Insured's Signature
Witness to Signatures	Patient Unable to Sign Consent Because: