ORION PHYSICAL THERAPY | ACTIVE ORTHOPEDICS

Patient Information Consent Form

I have read and fully understand Orion Physical Therapy/Active Orthopedics' Notice of Information Practices. I understand that Orion Physical Therapy/Active Orthopedics 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 Company in writing. I also understand that Orion Physical Therapy/Active Orthopedics 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 Orion Physical Therapy/Active Orthopedics Therapy Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

PATIENT NAME

SIGNATURE

DATE

Request signature from every patient.