



15811 Ambaum Blvd SW Suite 140, Burien WA 98166  
tel. 206.327.9880 ~ fax. 206.327.9977 ~ inquiry@lakeburienpt.com ~ www.lakeburienpt.com

### **PATIENT CONSENT AND RELEASE OF MEDICAL BENEFITS AUTHORIZATION**

I hereby consent to evaluation and treatment by my Physical Therapist. I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending Labor and Industries claims. I understand the parent accompanying a minor for treatment will be responsible for payment. I authorize Lake Burien Physical Therapy, Inc. to release any necessary information requested by my insurance carrier and authorize payment directly to Lake Burien Physical Therapy, Inc. for any benefits available under my insurance plan.

SIGNATURE: \_\_\_\_\_  
(Patient signature/relationship if patient is a minor)

DATE: \_\_\_\_\_

### **ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among health care providers who may be involved in that treatment directly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of Lake Burien Physical Therapy, Inc.'s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that Lake Burien Physical Therapy, Inc. has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.



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I understand that I may request, in writing, that Lake Burien Physical Therapy, Inc, restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that Lake Burien Physical Therapy, Inc, is not required to agree to my requested restriction, but if Lake Burien Physical Therapy, Inc, does agree then Lake Burien Physical Therapy, Inc is bound to abide by such restrictions.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DEPENDENT FAMILY MEMBERS ALSO COVERED BY THIS ACKNOWLEDGEMENT:

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