

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers in my treatment)
- Obtaining payment from third party payers (my insurance company)
- The day-to-day health care operations of your practice

HIPAA also requires that Advanced Motion Therapeutic, Inc. provide all patients with a Notice of Privacy Practices

Signature

Date

Non-Cancellation Policy

We are pleased to have you as a client at our facility and that we could set aside an appointment time to accommodate you. In consideration of our other clients who need therapy, we ask that if you are unable to keep an appointment with our office, that you please observe our non-cancellation policy outlined below.

We understand that sometimes it is necessary to cancel an appointment. Our office requires at least 24 hour's notice for all appointment cancellations.

If you are unable to provide 24 hours notice for cancellations, you will be billed a \$50.00 non cancellation charge.

For our records, please sign below that you have been informed and understand our non-cancellation policy. Please feel free to call our office with any questions.

Signature

Date

