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**15804 W. 6th Ave. Golden, CO 80401 Phone: (720) 696-0479**

Patient First and Last Name:

Street/Mailing Address:

Email: Date of Birth

Home Phone: Cell:

Referring Physician: Primary Physician

Emergency Contact & Relation: Phone#

**Employer Information**

Occupation: Employer:

Employer Address:

**Medical History**

Please answer the following the questions so we may be able to most effectively help you.

**Current Medical Conditions**:

**Medications & Supplements**:

**Surgical History**:

**What is/are the main reason(s) for your visit today?**

**Briefly describe how your problem began**:

**What goals would you like to achieve through therapy?**

**Date of onset/injury:**  **Date of surgery:**  **Type of Surgery**:

**INFORMED CONSENT TO TREAT**

I understand that 4 Corners Sports Performance LLC will maintain my privacy to the highest standards and 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. Any photographs taken during initial evaluation, progress evaluation and discharge summary will be used for movement analysis and educational purposes.

I do hereby agree and give my consent for 4 Corners Sports Performance LLC to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition. The doctor of physical therapy has informed me of any potential risks, advantages of treatments, and options I have for alternatives.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I have read and understand the above information and acknowledge that no guarantees or assurances can be given with regards to my treatment. I hereby authorize and direct 4 Corners Sports Performance LLC to provide me with the required rehabilitation services.

Printed Name Date

Patient Signature Date

**PAYMENT POLICY**

Payment accepted in the form of cash, check, or credit card/HSA card, is due at the time of each visit for the full amount due for the therapy or wellness services provided unless otherwise agreed upon. All physical therapy and sports performance services are provided without reimbursement from insurance companies and your insurance will not be billed for the services provided.

Payment is due at the time of service, if you are unable to pay at the time of service please notify us and we will do everything we can to work with you regarding payments. I have read and understand the above policies:

Printed Name Date

Patient Signature Date

**Authorization to Use and Disclose Health Information**

**Patient First and Last Name:**

With my consent, 4 Corners Sports Performance LLC may use and disclose protected health information(PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to 4 Corners Sports Performance LLC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. 4 Corners Sports Performance LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to 4 Corners Sports Performance LLC 15804 W. 6th Ave Golden, CO 80401.

With my consent, 4 Corners Sports Performance LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues and any calls pertaining to my clinical care, including test results among others.

With my consent, 4 Corners Sports Performance LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to 4 Corners Sports Performance LLC use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing to the extent that the practice has already made disclosure in reliance upon my prior consent.

**Patient Signature**:  **Date**:

**Parent/Guarding Signature (if under 18 years of age)**:

**Date**:  **/** /

**NOTICE OF PRIVACY PRACTICES (MEDICAL)**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.
We may use and disclosed your medical records only for each of the following purposes: treatment, payment and health care operations.

**Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
**Payment** means such activities as obtained reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

**Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

•  The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

•  The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

•  The right to inspect and copy your protected health information.

•  The right to amend your protected health information.

•  The right to receive an accounting of disclosures of protected health information.

•  The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.

4 Corners Sports Performance LLC

15804 W. 6th Ave

Golden, CO 80401

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights

200 Indepenence Avenue, S.W. Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Patient’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Website & Social Media Use Release Form**

**Authorization:** I give permission for images or videos captured during treatment for 4 Corners Sports Performance to be used solely for purposes of promotional material, social media, publication, and waive any rights for any compensation or ownership. By signing below I consent to the use of these photographs and videos in a professional manner. I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

**Purpose:** The photographic/video images, and/or testimonial will be used for: Social Media and/or Website Advertising.

**Revocability:** I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

**No Treatment Conditions:** I understand that the practice cannot condition treatment on whether or not I sign this authorization. If desired, copy can be provided

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_