CONSENT TO TREAT FORM

Consent for Purposes of Treatment, Payment, and Healthcare Operations:

I consent to the use or disclosure of my protected health information by InMotion Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of InMotion Physical Therapy. I understand that diagnosis or treatment of me by InMotion Physical Therapy may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, or health care operations of the practice. InMotion Physical Therapy is not required to agree to the restrictions that I may request. However, if InMotion Physical Therapy agrees to a restriction that I request, the restriction is binding on InMotion Physical Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that or InMotion Physical Therapy has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

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Signature of Patient or Personal Representative Date