Notice & Consent to Treat

Patient: **Today's Date:**

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge that you have been offered a copy for review of ATI's Notice of Privacy Practices which is prominently displayed in the clinic and available on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer at (630) 296-2222.

X_____ X_____
Patient/Guardian Signature Date

_____
Relationship to Patient

CONSENT TO TREAT & AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS

I hereby authorize ATI, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize ATI to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me reminders of my appointments via text messaging. I am assigning my therapy benefits to ATI for the services in which I receive and authorize my insurance carrier to make payments to ATI on my behalf. ATI reserves the right to seek reimbursement from any and all of your insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. All records released require an administrative and copying fee paid to ATI before they are released, regardless of requestor. ATI is HIPAA compliant with regard to information sharing policies.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued drivers license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above.

I further understand and acknowledge that ATI may lease or license real estate, equipment or other personal property (collectively "Leased Property") from third parties to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. In consideration of being permitted to make use of and/or have access to the Leased Property, I do hereby, on behalf of myself, on behalf of any minor or other person for whom I have requested such evaluation and treatment procedures ("Minor"), on behalf of my heirs, successors and assigns, and on behalf of such Minor's heirs, successors and assigns release and forever discharge any and all direct or beneficial owners of the Leased Property and their respective successors, related entities, directors, officers, employees, and agents (collectively, "Releasees") from, and hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with or while making use of the Leased Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releasees or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law.

X_____ X_____
Patient/Guardian Signature Date

Communication Preferences

Patient: **Today's Date:**

DIGITAL COMMUNICATION PREFERENCES

ATI Physical Therapy offers our patients exciting ways to stay connected to your treatment. Our digital services, known as ATI Connect, includes the ATI patient App and web portal, which give you easy visibility to import aspects of your treatment including progress towards your goals, access to your individualized video home exercise program, and appointment reminders, to name a few. We invite you to take advantage of this great companion to treatment!

☐ **Yes! Sign me up for ATI Connect, which includes services like the ATI App and web portal that gives me access to appointment reminders, view videos of my home exercise program, and monitor my treatment progress. I will also receive exciting information regarding ATI's products and services, which I can opt out of at any time.**

Email Address: _____

☐ **No, I do not wish to provide my email for these services at this time**

X_____ X_____
Patient/Guardian Signature Date

_____
Relationship to Patient

Consent to Communicate to Others

I hereby authorize ATI, through its appropriate personnel, to communicate with _____, my (circle one) **husband / wife / mother / father / son / daughter / significant other / friend** regarding billing and payment for services rendered on my behalf. I understand that ATI will attempt to verify the identity of those I authorize to communicate regarding billing and payment by way of seeking confirmation of the answers to at **least 2** of the following questions:

1) **Patient's mother's maiden name is** _____.

2) **City in which the patient was born** _____.

3) **Birthday of the patient is** _____.

4) **Name of patient's current pet is** _____.

5) **Zip code of the patient's mailing address is** _____.

☐ **I wish to decline authorization for others to communicate with ATI on my behalf.**

X_____ X_____
Patient/Guardian Signature Date