CONSENT FOR CARE AND TREATMENT

I, the undersigned, do herby agree and give consent for Cooperative Performance & Rehabilitation ,LLC to furnish medical care and treatment necessary in treating his/her physical condition.

⇒_______________________________________ _______________________________
Signature of Patient/Guardian **Date**

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third party payers to Cooperative Performance & Rehabilitation. A photo copy of this assignment is information necessary including Medical records, to secure payment.

⇒_______________________________________ _______________________________
Signature of Patient/Guardian **Date**

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I herby authorize Cooperative Performance & Rehabilitation, LLC to obtain any and all medical records concerning my care from any physician, hospital or health care professional that has provided medical care to me in the past.

I also authorize Cooperative Performance & Rehabilitation , LLC practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at anytime.

⇒_______________________________________ _______________________________
Signature of Patient/Guardian **Date**

ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the Practice's "HIPPA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPPA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPPA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPPA Privacy Notice.

I further acknowledge that the Practice can change its HIPPA Privacy Notice n the future and that I can receive a copy of the Practice's current Privacy Notice at anytime.

I understand that I have the right to request that the Practice restrict its users and disclosures of my health information for treatment, payment or health care operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.

I do not request any restrictions on the Practice's uses and disclosures of my health information for treatment, payment or health care operations. ⇒________**(Initial)**

By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance of this consent.

⇒_______________________________________ _______________________________
Signature of Patient/Guardian **Date**