3300 Behrman Pl, New Orleans, LA 70114, Office 504-374-0015 Fax 504-374-0016 ~ 5555 Bullard Ave Su 102 * New Orleans, LA, 70128 Office 504-245-2483 Fax 504-245-2489

Notice of Patient Information Practices
Xtreme Physical Therapy's LEGAL DUTY

Xtreme Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices described herein. You have the right to receive a copy of our legal duties and privacy practices with respect to protect health information. If you would like a copy please ask. By signing below, I hereby acknowledge I am aware of and have been offered a copy of this notice

_____ _____
Signature (Parent if patient is minor) Date

I also authorize Xtreme Physical Therapy to use my personal health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____ _____
Signature (Parent if patient is minor) Date

I authorize Xtreme Physical Therapy to release information to my insurance company and/or Attorney and/or Employer. Where applicable I authorize direct payment of benefits to Xtreme Physical therapy for services rendered.

_____ _____
Signature (Parent if patient is minor) Date

The Patient and/or authorized representative of the patient, whose signature is affixed below, does hereby consent to any and all medical treatments at Xtreme Physical Therapy, LLC which may be deemed advisable by my/the patient's physicians, the intent hereof being to grant authority to administer and perform all therapies which may now or during the course of my/the patient's care be deemed advisable or necessary.

_____ _____
Signature (Parent if patient is minor) Date

If you are unable to keep your appointment, or run late, we ask that you please notify us as soon as possible so that the appointment will be available for someone else. If proper notice is not receive, your referral source and insurance company will be notified of each missed appointment. We may assess a fee for repeated missed appointments which are not cancelled in a timely manner.

_____ _____
Signature (Parent if patient is minor) Date