AUTHORIZATION FOR TREATMENT

I hereby request and consent to treatment of physical therapy at *Impact Health and Performance (aka Provider).* I understand the Provider will place hands on me to provide therapy services. I consent to Provider's hands on me during the rendition of therapy services and agree to cooperate with all reasonable requests which Provider, in the exercise of reasonable clinical judgment, believes necessary to achieve the objectives of the treatment Plan of Care.

NOTICE OF PRIVACY PRACTICES

Your protected health information will be used by Impact Health and Performance, LLC for the purpose of treatment. We do not disclose your private information to third parties, unless authorized by you. You have the right to view our entire Notice of Privacy Practices upon request.

SIGNATURE

Please sign below, giving Impact Health and Performance authorization for treatment and to also acknowledge our notice of privacy practices, as stated above.

Patient's Name: ____ Date: ________________

Signature of Patient: ____

Impact Health Staff: ____

Impact Health and Performance Phone: 727-785-8737 Fax: 727-786-8546