SIGNATURE PAGE FOR PRIVACY PRACTICES & CONSENT TO DISCLOSE MEDICAL INFORMATION

ZENERGY PHYSICAL THERAPY
13710 Metropolis Ave #106
Fort Myers, FL 33912

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I, _____HEREBY ACKNOWLEDGE THAT I HAVE REVIEWED A COPY OF NOTICE OF PRIVACY PRACTICES FROM ZENERGY PHYSICAL THERAPY LLC .PRIOR TO RECEIVING SERVICES. (***COPY AVAILABLE ONLINE AT ZENERGYPT.COM)***

SIGNATURE:_____ DATE: _____

CONSENT TO DISCLOSE MEDICAL INFORMATION

We may need to contact you by telephone at one of the numbers you have provided us. We would like to know who we can talk to and/or what type of message to leave.

My protected Health Information can be released to the following Persons:
Name: _____ Relationship: _____
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

I authorize this information to be used or disclosed for the following purpose:

- ☐ To patient's primary physician and other professionals involved in patient treatment.
- ☐ To another health care provider, at the patient's request, for second opinions, continuing care etc.
- ☐ To an attorney, at the patients request
- ☐ To patient's health insurance provider for billing related purposes
- ☐ To an insurance company If accident or work related injury (life, automobile, disability etc)

I understand that I may revoke or change this consent at anytime by filling out another consent form to replace this one.

SIGNATURE: _____DATE:_____

RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS

I, _____AUTHORIZE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE: _____ DATE: _____