PATIENT INFORMATION CONSENT FORM

I have read and fully understand Sovereign Rehabilitation's Notice of Patient Information Practices.

I understand that Sovereign Rehabilitation may use or disclose my personal health information for the purpose or carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that Sovereign Rehabilitation will consider request for restriction on a case-by-case basis, but does not have to agree with the request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Sovereign Rehabilitation's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

Patient Name (PRINT)_____ Date:_____

Signature:_____

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION.
Sovereign Rehabilitation 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 that are described herein**.**

USES AND DISCLOSURES OF HEALTH INFORMATION
Sovereign Rehabilitation uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Sovereign Rehabilitation may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Sovereign Rehabilitation may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation, Sovereign Rehabilitation's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Sovereign Rehabilitation may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances Sovereign Rehabilitation will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

Cancellation & No-Show Policy

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. **It is your responsibility to make every effort to keep your scheduled appointment and to arrive promptly at the scheduled time**. We do realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to the other patients that need to be seen as soon as possible, we hereby request that you notify our office immediately when you realize you will not be keeping your appointment.

If you need to cancel or reschedule your appointment, you must do so at least 24 hours before your schedule office visit to avoid paying a $25.00 fee. This is not covered by your medical insurance or Workers Compensation benefits. This notice of 24 hours is necessary so that we may schedule other patients needing immediate appointments.

This fee must be paid on or before your next scheduled appointment.

Worker's Compensation Patients

Please note that we will need to notify your adjuster and/or Nurse Case Manager in the event that you cancel/ reschedule your appointment.

I hereby acknowledge that I have read and understand the above cancellation and no show policy and that I agree to abide by these guidelines.

_____ _____

Patient Signature Date