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Privacy Policy:

Hands On Healing Physical Therapy, LLC values your privacy. During the course of treatment, private health information is collected that is necessary for your care. This information is confidential and we recognize the importance of protecting it. You may obtain a copy of our complete HIPAA Notice of Privacy Practices upon request. By signing below I acknowledge that I have been permitted access and/or have a copy of this information.

Patient Name: _____

Patient Signature: _____ Date: _____
(Guardian if under 18)

Release of Information:

Hands On Healing Physical Therapy, LLC feels it is important to communicate with your physicians and other practitioners involved in your care in order to achieve the best outcomes for our patients. The exchange of information will only be what is necessary for your treatment. At times it may be necessary to communicate with your insurance company and exchange information in order for them to process and pay your claims. By signing below you authorize Hands On Healing Physical Therapy, LLC to exchange medical and other information pertinent to your care.

Patient Name: _____

Patient Signature: _____ Date: _____
(Guardian if under 18)

Payment Agreement:

I agree to pay Hands On Healing Physical Therapy, LLC in full at the time of service. Cash, check, or credit card are accepted methods of payment. Rates are $100 for 1 hour, $50 for ½ hour.

Patient Name: _____

Patient Signature: _____ Date: _____
(Guardian if under 18)