



Advanced Center for Physical Therapy, PLC
Greene County Office
 5928 Seminole Trail, Suite 103
 Barboursville, VA 22923
 Phone: (434) 985-2198
 Fax: (434) 985-3227

Charlottesville Office
 2114 Angus Road, Suite 107
 Charlottesville, VA 22901
 Phone: (434) 295-4473
 Fax: (434) 295-2691

Patient Results Agreement

Your comments are extremely important to us and to others who choose to come to Advanced Center for Physical Therapy to get great results. This form gives us permission to enter your results in our:

- SUCCESS STORY BOOK
- NEWSLETTER

Please check the box of your choice.

 Patient's Signature

 Date

PATIENT PRIVACY CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Further, you permit a copy of this authorization to be used in place of the original.

CONFIDENTIAL COMMUNICATION INFORMATION

Patient's Full Name: _____ DOB: ___/___/___ SS#: ___-___-___

Please choose where we can contact you about your therapy appointments, care and/or billing issues:

Home phone #: _____ Work phone #: _____ Cell phone #: _____

Please choose where we can leave a message about your therapy appointments, care and/or billing issues:

Home Work Cell

Who can we leave a message with? No restrictions

Individuals approved to leave a message with:

Do you want the billing information sent to an alternative address? Yes No

If yes, please include full address and phone number: _____

 Phone #: _____

 Patient's Signature (Parent/Guardian if patient is a minor)

 Date

 Witness

 Date